MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08106

' 8105 CERTIFICATE OF DEATH Reg. Dist. No. 302

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY Hagerstown Wash. MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Md.
LENGTH OF STAY (in this place) 45yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Washington County Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Washington
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hagerstown, Maryland
STREET ADDRESS (If rural give location) 336 Blooms Court.

3. NAME OF DECEASED: (Type or Print) George (First) Earl (Middle) Adams (Last)

4. DATE OF DEATH: (Month) 8 (Day) 15 (Year) 19 55

5. SEX: Male

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Widowed

8. DATE OF BIRTH: April 15 1884

9. AGE last birthday: 71 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laberer

10B. KIND OF BUSINESS OR INDUSTRY: W. Md Railroad

11. BIRTHPLACE (State or foreign country): Kellers [illegible] Va.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Neal F. Admas

14. MOTHER'S MAIDEN NAME: Elizabeth Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. 205-10-7435

17. INFORMANT & ADDRESS: Mrs. Bertie Yates

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

443X
IMMEDIATE CAUSE

(A) Hypertensive Cardio-Vascular Disease — INTERVAL BETWEEN ONSET AND DEATH ? -

ANTECEDENT CAUSE (S)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

DUE TO (B) Generalized Arterio Sclerosis ? -

DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. 0

19A. DATE OF OPERATION: 0

19B. MAJOR FINDINGS OF OPERATION 0

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 0

21B. PLACE (Home, farm, factory, office bldg., etc.) OF INJURY 0

21C. WHERE DID INJURY OCCUR? (City or town) 0 (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 0 M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR? 0

22. I hereby certify that I attended the deceased from 8/8, 19 55, to 8/15, 19 55, that I last saw the deceased alive on 8/15, 19 55, and that death occurred at 3:30 P. M, from the causes and on the date stated above.

SIGNATURE Victor D Miller M. D. ADDRESS DATE SIGNED 8/17-1955

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

DATE THEREOF 8-18-1955

NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery

LOCATION (City, town, or county) (State) Hagerstown, Maryland

DATE REC'D BY LOCAL REGISTRAR Aug. 18, 1955

REGISTRAR'S SIGNATURE C. Chas. H. Bowers

24. FUNERAL DIRECTOR John R Watson ADDRESS Hagerstown Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08107

8143

CERTIFICATE OF DEATH

Reg. Dist. No. 201

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY: Washington — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural Hancock
LENGTH OF STAY (in this place): 75 Yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Home

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland Washington COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural Hancock Md.
STREET ADDRESS (If rural give location): R.F.D.1 Hancock Md.

3. NAME OF DECEASED: (Type or Print) (First) Charles (Middle) Chas (Last) Barnhart

4. DATE OF DEATH: (Month) 8 (Day) 30 (Year) 19 55

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: Sept. 5 1869

9. AGE Last birthday: 85 yrs. IF UNDER 1 YEAR: Months 11 Days 24 IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: Farming

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): Fulton County Penna.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Barnhart

14. MOTHER'S MAIDEN NAME: Not Known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): No (If Yes, give war or dates of service): No

16. SOCIAL SECURITY No.: None

17. INFORMANT & ADDRESS: Theodore F Barnhart Route 1 Hancock Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X

Immediate cause (a) Cerebral Hemorrhage — Interval Between Onset And Death: 8 hours

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

DUE TO (b) Hypertension

DUE TO (c) Advanced Arteriosclerosis

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1955 to 8-29, 1955, that I last saw the deceased alive on 8-10, 1955 and that death occurred at 8.15 AM from the causes and on the date stated above.

SIGNATURE (Degree or title): Herbert R. Tobin M.D. ADDRESS: Hancock Md DATE SIGNED: 8-30-55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: 9.2.55

NAME OF CEMETERY OR CREMATORY: Mt Olivet Cemetery

LOCATION (City, town, or county) (State): Hancock Washington Md.

DATE REC'D BY LOCAL REGISTRAR: 9-2-55

REGISTRAR'S SIGNATURE: J.A. Keller

24. FUNERAL DIRECTOR: Howard P. Stone Hancock Md ADDRESS

MARYLAND STATE DEPARTMENT OF HEALTH

08108

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

8106

Reg. Dist. No. 302

1. PLACE OF DEATH: COUNTY WASHINGTON; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN HAGERSTOWN; LENGTH OF STAY (In this place) 03; HOSPITAL OR INSTITUTION OR STREET ADDRESS WESTERN MARYLAND RAIL ROAD STORES DEPT.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND; COUNTY WASHINGTON; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN RURAL HAGERSTOWN; STREET ADDRESS (If rural, give location) RT.#4

3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	PERCY	GLENN	BARTLES		AUGUST	15	1955

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
MALE	WHITE		12/24/1893	61 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY
LABORER STORE HOUSE	RAIL ROAD	MARYLAND	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
WILLIAM BARTLES	SUSAN E. KING

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
YES	W.W.#1	722-12-3037	MR. VICTOR O. BARTLES RT.#4 HAGERSTOWN MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
420.1		
Immediate cause	(a)	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertensive cardio vascular disease	5yrs
	(c) Acute coronary occlusion----	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
none	-	Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
	none	-	-	-

TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?
none m.		-

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
J. Robert Wells, M.D. DEPUTY MEDICAL EXAM. WASH. CO., MD.	115 N. Potomac St- Hagerstown, Md.	8-16-55

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	8/17/55	Rest Haven Mem.	Hagerstown Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Aug. 16 1955	Chas. H. Boward	W. J. Hornkut	Hagerstown Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

8107

CERTIFICATE OF DEATH

08109

Reg. Dist. No. 302

1. PLACE OF DEATH
COUNTY: Washington
MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: 03 Hagerstown
LENGTH OF STAY (in this place): 3 Months
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 81 Washington County Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland
COUNTY: Frederick
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Point of Rocks
STREET ADDRESS (If rural, give location): 10 x - 2

3. NAME OF DECEASED (Type or Print): (First) RUTH (Middle) ELEANOR (Last) BENNETT

4. DATE OF DEATH: (Month) August (Day) 22, (Year) 1955

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Seperated

8. DATE OF BIRTH: Jan. 1, 1905

9. AGE last birthday: 50 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: James F. French

14. MOTHER'S MAIDEN NAME: Ethel V. Anderson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: ?

17. INFORMANT AND ADDRESS: James M. French, Point of Rocks, Maryland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

1748

Immediate cause (a) Metastatic Carcinoma of the Body.

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Carcinoma of the Uterus -

(c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: X

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 21 June, 1955, to 21 Aug, 1955, that I last saw the deceased alive on 21 Aug, 1955, and that death occurred at 7:22 A m., from the causes and on the date stated above.

SIGNATURE: John LaPorte (Degree or title) M.D. ADDRESS: 115 King Street DATE SIGNED: 22 Aug 1955

23. BURIAL, CREMATION, REMOVAL (Specify): Cremation
DATE THEREOF: Aug. 25 1955
NAME OF CEMETERY OR CREMATORY: Fort Lincoln Crematory
LOCATION (City, town, or county) (State): Washington, D. C.

DATE REC'D BY LOCAL REG.: Aug. 23, 1955
REGISTRAR'S SIGNATURE: Chas. H. Bowers

24. FUNERAL DIRECTOR ADDRESS: M. R. Etchison & Son, Frederick, Maryland

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08110

CERTIFICATE OF DEATH

8108

Reg. Dist. No. 302

1. PLACE OF DEATH:
COUNTY Washington MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown
LENGTH OF STAY (in this place) 16 hrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 81 Wash. County Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Anne Arundel
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jessup 02 x-2
STREET ADDRESS (If rural give location) Champion Forrest

3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print) Unnamed child of Doris Bolles

4. DATE OF DEATH: (Month) Aug (Day) 10 (Year) 1955

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Single
8. DATE OF BIRTH: Aug 10, 1955
9. AGE last birthday: --- yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours 16 Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ----
10B. KIND OF BUSINESS OR INDUSTRY: ----
11. BIRTHPLACE (State or foreign country): Hagerstown Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Donald Daugherty
14. MOTHER'S MAIDEN NAME: Doris Bolles

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) --
(If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. --
17. INFORMANT & ADDRESS: Miss Doris Bolles Jessup Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:
762.5
IMMEDIATE CAUSE (A) Atelectasis — INTERVAL BETWEEN ONSET AND DEATH 16 hrs.
ANTECEDENT CAUSE (S)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST
DUE TO (B) Prematurity 6½ months
DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Minimal Subarachnoid Hemorrhage

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from birth, 19 , to 8/11, 1955, that I last saw the deceased alive on 8/11, 1955, and that death occurred at 5:40 P.M., from the causes and on the date stated above.
SIGNATURE Walter H. Sheats M. D. ADDRESS Smithsburg, Md. DATE SIGNED 8/11/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF 8-12-55
NAME OF CEMETERY OR CREMATORY Locust Valley Fr. Co.
LOCATION (City, town, or county) (State) Burkittsville Md.

DATE REC'D BY LOCAL REGISTRAR Aug. 11, 1955
REGISTRAR'S SIGNATURE Chas. H. Bowers
24. FUNERAL DIRECTOR Scott F. Minnich & Son ADDRESS Hag. Md.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-55

20851612850

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08111

Item 14, Fi[illegible]

8141

CERTIFICATE OF DEATH

Reg. Dist. No. 305

1. PLACE OF DEATH:
COUNTY WASHINGTON MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X TOWN BEAVER CREEK-RURAL
LENGTH OF STAY (in this place) LIFE
HOSPITAL OR INSTITUTION OR STREET ADDRESS HAGERSTOWN MD. R.1.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND. COUNTY WASHINGTON
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN BEAVER CREEK - RURAL X
STREET ADDRESS (If rural give location) HAGERSTOWN MD. R.1

3. NAME OF DECEASED: (Type or Print) (First) LEWIS (Middle) CHARLES (Last) BOWERS

4. DATE OF DEATH: (Month) AUGUST (Day) 15 (Year) 1955

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED

8. DATE OF BIRTH: MAY-20-1905

9. AGE last birthday: 50-2-25 Yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): GRINDER.

10B. KIND OF BUSINESS OR INDUSTRY: PANGBORN CORP.

11. BIRTHPLACE (State or foreign country): BEAVER CREEK WASH.CO.MD.

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: CHARLES BOWERS

14. MOTHER'S MAIDEN NAME: Carrie Fulton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) YES (If Yes, give war or dates of service) WW. 2.

16. SOCIAL SECURITY NO. 214-09-6113

17. INFORMANT & ADDRESS: MRS. ELSIE BOWERS. HAGERSTOWN MD.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE 4. 1
(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 6 wks

ANTECEDENT CAUSE (S)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.
(B) DUE TO
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 3, 1955, to Aug 15, 1955, that I last saw the deceased alive on Aug 15, 1955, and that death occurred at 8.5 M, from the causes and on the date stated above.
SIGNATURE [signature] M. D. ADDRESS Boonsboro DATE SIGNED Aug 16, 1955

23. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL
DATE THEREOF: AUG-19-1955
NAME OF CEMETERY OR CREMATORY: BEAVER CREEK CEMETERY
LOCATION (City, town or county) (State): BEAVER CREEK MD

DATE REC'D BY LOCAL REGISTRAR: Aug. 17. 1955
REGISTRAR'S SIGNATURE: John H. Bast
24. FUNERAL DIRECTOR ADDRESS: WM. F. BAST AND SONS BOONSBORO MD.

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08112

CERTIFICATE OF DEATH

8109 Reg. Dist. No. 302

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

COUNTY Washington MARYLAND

CITY (If outside corporate limits, write RURAL) OR TOWN and give nearest town) Hagerstown

LENGTH OF STAY (in this place) 5 days

HOSPITAL OR INSTITUTION OR STREET ADDRESS Washington County Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Washington

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown

STREET ADDRESS (If rural give location) 105 N. Locust Street

3. NAME OF DECEASED: (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH: (Month)	(Day)	(Year)
IRA	CLAYTON	BRANDENBURG	August	20	1955

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS Hours	Min.
Male	White	Widowed	October 23, 1887	67 yrs.	9	27		

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Machinest	Fairchild Aircraft	Frederick County Maryland	U.S.A.

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Levi H. Brandenburg	Lousia C. Grossnickle

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY No.:	17. INFORMANT & ADDRESS:
no		219-05-2163	Mr. Harry E. Brandenburg Hagerstown, Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause 420.0 (a) Acute Myocardial Failure — Interval Between Onset And Death: 1 week

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Arteriosclerotic Heart Disease — 7 yrs

DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURED While at Work ☐ Not While At Work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 1946, 19.. to 8/20/55, 19.., that I last saw the deceased alive on 8/20/55, 19.., and that death occurred at 2.30 P.M. from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
Hart Young MD	Hagerstown MD	

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	8/23/55	Smithburg Cemetery	Smithburg, Maryland

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Aug 23. 1955	Chas H. Bowers	C. M. Suter & Sons	Hagerstown, Maryland

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

8145

09116

Reg. Dist. No. 3-C

1. PLACE OF DEATH: COUNTY WASHINGTON; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X RURAL; LENGTH OF STAY (In this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS KNOXVILLE M.R.I.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND; COUNTY WASHINGTON; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN - RURAL -; STREET ADDRESS (If rural, give location) KNOXVILLE MD. R.1

3. NAME OF DECEASED (Type or Print): (First) JOSEPH (Middle) THOMAS (Last) BROWN

4. DATE OF DEATH: (Month) AUGUST (Day) 15 (Year) 1955

5. SEX: MALE

6. COLOR OR RACE: COLORED

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED

8. DATE OF BIRTH: MAY 23 1882

9. AGE last birthday: 73 Years 2 Months 22 Days; If under 1 year: Hours; If under 24 hrs: Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FREIGHT HANDLER RETIRED

10b. KIND OF BUSINESS OR INDUSTRY: B&O R.R. Co.

11. BIRTHPLACE (State or foreign country): WASH. Co. MD.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ALBERT BROWN

14. MOTHER'S MAIDEN NAME: ELIZA SMALLWOOD

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): (If yes, give war or dates of service) No

16. SOCIAL SECURITY No. 219-01-7385

17. INFORMANT AND ADDRESS: MRS. AMANDA BROWN KNOXVILLE MD. R.1.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral Hemorrhage	24 hrs
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Starvation & exhaustion	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Mentally Ill

19a. DATE OF OPERATION None

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) None m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy _, Inspection X, Inquiry _ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes, accident _, suicide _, homicide _, undetermined _.*

SIGNATURE (Degree or title) S. Robert Wells M.D. DEPUTY MEDICAL EXAMINER WASH. CO., MD.

ADDRESS 115 N. Potomac St- Hagerstown, Md.

DATE SIGNED Sept. 9 '55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF 9-10-55

NAME OF CEMETERY OR CREMATORY Baptist

LOCATION (City, town, or county) (State) Forest Hills, Md.

DATE REC'D BY LOCAL REG. Sept. 12-1955

REGISTRAR'S SIGNATURE Katherine Hagenbuch

24. FUNERAL DIRECTOR C. A. Fuhr & Bro

ADDRESS Brunswick, Md.

VS. A15A

I MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08113

8110 CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:
COUNTY Washington MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown Maryland
LENGTH OF STAY (in this place) 2 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Washington County Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Washington
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Maryland
STREET ADDRESS (If rural give location) 458 Sumans Avenue

3. NAME OF DECEASED: (Type or Print) James Washington Calaman (First) (Middle) (Last)

4. DATE OF DEATH: (Month) 8 (Day) 26 (Year) 1955

5. SEX: Male

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed

8. DATE OF BIRTH: June 8 1889

9. AGE last birthday 66 yrs
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farm hand

10B. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (State or foreign country): Keedysville, Md.

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: Daniel Calaman

14. MOTHER'S MAIDEN NAME: Mary L. Thomas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)

(If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. 220-09-9130

17. INFORMANT & ADDRESS: Charles Washington 458 Sumans Ave

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

416X

IMMEDIATE CAUSE (A) Rheumatic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 4 years.

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (B) Acute Endocar — DUE TO: 2 days.

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/13, 19 53, to 8/26, 1955, that I last saw the deceased alive on 8/26, 19 55, and that death occurred at 9 00 A.M., from the causes and on the date stated above.

SIGNATURE [signature] M. D. ADDRESS Hagerstown Md DATE SIGNED 8/29/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

DATE THEREOF 8-31-1955

NAME OF CEMETERY OR CREMATORY Red Hill Cemetery

LOCATION (City, town, or county) (State) Keedysville Maryland

DATE REC'D BY LOCAL REGISTRAR Aug. 31, 1955

REGISTRAR'S SIGNATURE Chas H. Bowers

24. FUNERAL DIRECTOR John R Watson Jr ADDRESS Hagerstown Md.

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

8146

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist. 0811

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 305

1. PLACE OF DEATH:
COUNTY Washington MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Funkstown Md RFD 40A
LENGTH OF STAY (In this place) 10 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Funkstown Md. RFD 40 A

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Washington
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Funkstown Md RFD 40 A X
STREET ADDRESS (If rural, give location) Funkstown Md. RFD 40 A

3. NAME OF DECEASED: (Type or Print) (First) Carl (Middle) (Last) Chaney

4. DATE OF DEATH (Month) Aug. (Day) 15 (Year) 19 55

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: 1910

9. AGE last birthday: 45 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Farm Labor

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (State or foreign country): Downsville Dist. Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Percy Chaney

14. MOTHER'S MAIDEN NAME: Sadie Ellen Cline

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) No

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: White Hall Opphanage Mrs. Lenora Reeves Chambersburg Pa. RFD

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) Gun shot into abdomen — Interval between onset and death: about 30 min

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: none

19b. MAJOR FINDING OF OPERATION: -

20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY) Home

21c. (City or town) R # 40 -Funkstown (County) (State) Washington

21d. TIME OF INJURY (Month) (Day) (Year) 8 · 15 · 55 (Hour) about 12 noon

21e. INJURY OCCURRED While at work ☐ Not while at work ☒

21f. HOW DID INJURY OCCUR? shot by uncle at home

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☒, Undetermined cause ☐.

SIGNATURE Robert Wells M. D.

CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAM. ☒

DATE SIGNED 8 · 16 · 55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF Aug. 18-55

NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery

LOCATION (City, town, or county) (State) Williamsport Md.

DATE REC'D BY LOCAL REG. Aug 18 1955

REGISTRAR'S SIGNATURE John H. Bard

24. FUNERAL DIRECTOR Albert L. Leaf ADDRESS Williamsport Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A - 5 - 53

8147

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08115 Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 205

1. PLACE OF DEATH:
COUNTY Washington MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Funkstown Md RFD 40 A
LENGTH OF STAY (In this place) 10 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Funkstown Md RFD 40 A

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Washington
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Funkstown Md. RFD 40 A
STREET ADDRESS (If rural, give location) Funkstown Md. RFD 40 A

3. NAME OF DECEASED: (Type or Print) (First) David (Middle) Henry (Last) Chaney

4. DATE OF DEATH (Month) Aug. (Day) 15 (Year) 1955

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: Feb. 5 1881

9. AGE last birthday: 74 yrs. IF UNDER 1 YEAR: Months 6 Days 9 IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (State or foreign country): Blairs Valley Wash. Co.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles Chaney

14. MOTHER'S MAIDEN NAME: Celia (last Unknown)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) No

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: RFD #2 Mrs. John A. Bopp Williamsport Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

97% X

Immediate cause (a) Gun shot wound thru chest in region of heart — Interval between onset and death: 5 min. about

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) hemorrhage and shock

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: none

19b. MAJOR FINDING OF OPERATION: —

20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY Home

21c. (City or town) (County) (State) R # 40 A- Funkstown, Washington

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY 8-15-55 2:00 PM

21e. INJURY OCCURRED While at work ☐ Not while at work ☒

21f. HOW DID INJURY OCCUR? Shot self after having shot 2 other people

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined cause ☐.

SIGNATURE S. Robert Wells M. D.

CHIEF MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAM. ☐

DATE SIGNED 8-16-55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF Aug. 18-55

NAME OF CEMETERY OR CREMATORY Bakersville Cemetery

LOCATION (City, town, or county) (State) Bakersville Md.

DATE REC'D BY LOCAL REG. Aug. 18 1955

REGISTRAR'S SIGNATURE John A. Beck

24. FUNERAL DIRECTOR Albert L Leaf

ADDRESS Williamsport Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A - 5 - 53

8148

08116

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 302

1. PLACE OF DEATH:
COUNTY Washington MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Funketown
LENGTH OF STAY (in this place) –
HOSPITAL OR INSTITUTION OR STREET ADDRESS E. Baltimore St.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Washington
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Rural Hagerstown
STREET ADDRESS (If rural, give location) Rt. 1

3. NAME OF DECEASED: (Type or Print) (First) John (Middle) Edward (Last) Chaney

4. DATE OF DEATH (Month) Aug (Day) 7 (Year) 19 55

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE Last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Single	Feb. 1, 1939	16 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
		Hagerstown Md.	

13. FATHER'S NAME: Harry E. Chaney

14. MOTHER'S MAIDEN NAME: Phyllis Snyder

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY No.:	17. INFORMANT & ADDRESS:
No	15-34-743	Harry E. Chaney Rt. 1

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Fracture ribs; lacerted lungs; hemorrhage and shock	5 min
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) DUE TO	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes ☐ No ☑
--	-	

21a. EXTERNAL CAUSE WAS PRIMARY ☑ or CONTRIBUTING ☐ CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY Street	21c. (City or town) Funkstown	(County) Washington	(State) Maryland

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED While at work ☐ Not while at work ☑	21f. HOW DID INJURY OCCUR?
8- 7-55 2:30A M.		Driver of car that hit embankment & crashed

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☑, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE J. Robert Wells M. D. CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☑ ASSISTANT MEDICAL EXAM. ☐ DATE SIGNED 8-8-55

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Aug. 9, 1955	Rest Haven Cemetery	Hagerstown Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Aug. 8, 1955	Ethel H. Bowers	Scott F. Minnich & Son	Hag. Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A - 5 - 53

8149

08117

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 305

1. PLACE OF DEATH:
COUNTY Washington MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Funkstown Md RFD40 A
LENGTH OF STAY (in this place) 10 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Funkstown Md RFD 40 A.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Washington
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Funkstown Md. RFD 40 A
STREET ADDRESS (If rural, give location) Funkstown Md. RFD 40 A.

3. NAME OF DECEASED: (Type or Print) (First) Sadie (Middle) Ellen (Last) Chaney

4. DATE OF DEATH (Month) Aug. (Day) 15 (Year) 1955

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: May 9 1884

9. AGE last birthday: 71 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Downsville Dist. Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Levy Cline

14. MOTHER'S MAIDEN NAME: Martha Detrow

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) No

16. SOCIAL SECURITY NO.: None

17. INFORMANT & ADDRESS: White Hall Orphanage Mrs. Lenora Reeves Chambersburg PaRFD

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) Gun shot wound thru chest — INTERVAL BETWEEN ONSET AND DEATH: 5 min

DUE TO hemorrhage and shock

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:

19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY Home

21c. (City or town) R # 40 A - Funkstown, (County) Washington (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 8/16/55 @12 Noon EST

21e. INJURY OCCURRED While at work ☐ Not while at work ☒

21f. HOW DID INJURY OCCUR? Shot by brother-in law

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☒, Undetermined cause ☐.

SIGNATURE L. Robert Mills M. D.

CHIEF MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAM. ☐

DATE SIGNED 8-16-55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF Aug. 18-55

NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery

LOCATION (City, town, or county) (State) Williamsport Maryland

DATE REC'D BY LOCAL REG. Aug. 18 1955

REGISTRAR'S SIGNATURE John H. Bast

24. FUNERAL DIRECTOR ADDRESS Albert L. Leaf Williamsport Md.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 (8213)

8111 CERTIFICATE OF DEATH

Reg. Dist. No. 302

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-[illegible]

1. PLACE OF DEATH:
COUNTY Washington
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown
MARYLAND LENGTH OF STAY (in this place) 1 mo. 10 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS 81 Wash. Co. Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY Washington
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hagerstown
STREET ADDRESS (If rural give location) 749 Preston Road

3. NAME OF DECEASED: (Type or Print) (First) Elizabeth (Middle) Kirkwood (Last) Colton

4. DATE OF DEATH: (Month) Aug. (Day) 21 (Year) 1955

5. SEX Female

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH. August 6, 1911

9. AGE last birthday 44 yrs. IF UNDER 1 YEAR Months 0 Days IF UNDER 24 HRS Hours Min. 15

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country) St. Clairsville, Ohio

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Albert W. Kennon, Sr.

14. MOTHER'S MAIDEN NAME: Ida Updegraff

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) NO (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. NONE

17. INFORMANT & ADDRESS John M. Colton, Hagerstown, Md.

18. MEDICAL CERTIFICATION

			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
2.41 IMMEDIATE CAUSE	(A) DUE TO	Lymphosarcoma	4 yrs.
ANTECEDENT CAUSE (B)		Myelogenous Leukemia	2 mos.
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	(B) DUE TO		
	(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			

19A. DATE OF OPERATION Nov. 1951

19B. MAJOR FINDINGS OF OPERATION Follicular Lymphoblastoma.

20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/20/, 1951, to 8/21/, 1955, that I last saw the deceased alive on 8/21/, 1955, and that death occurred at 9:20 PM, from the causes and on the date stated above.

SIGNATURE Philip Wollman M. D. ADDRESS DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation

DATE THEREOF 8/25/55

NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery

LOCATION (City, town, or county) (State) Washington, D. C.

DATE REC'D BY LOCAL REGISTRAR Aug 23, 1955

REGISTRAR'S SIGNATURE Chas H Bowers

24. FUNERAL DIRECTOR ADDRESS C. M. Suter & Sons, Hagerstown, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08119

8112 **CERTIFICATE OF DEATH** Reg. Dist. No. 302

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH: COUNTY Washington MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown
LENGTH OF STAY (in this place) 5 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Washington Co. Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Washington
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport
STREET ADDRESS (If rural give location) 16 South Vermont St.

3. NAME OF DECEASED: (Type or Print) (First) Massarene (Middle) (Last) Corby

4. DATE OF DEATH: (Month) Aug. (Day) 5 (Year) 1955

5. SEX: Female | 6. COLOR OR RACE: White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Single | 8. DATE OF BIRTH. Sept. 25, 1883 | 9. AGE last birthday 71 yrs. | IF UNDER 1 YEAR Months 10 Days 10 | IF UNDER 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk | 10B. KIND OF BUSINESS OR INDUSTRY: Grocery Store | 11. BIRTHPLACE (State or foreign country): Williamsport | 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Joseph Corby

14. MOTHER'S MAIDEN NAME: Laura Tice

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT & ADDRESS: Joseph Corby Washington, D. C.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.1
IMMEDIATE CAUSE (A) Coronary Occlusion — 4 days

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.
DUE TO (B)

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Diabetes Mellitus — 3 yrs.

19A. DATE OF OPERATION: None | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | 21E. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 18, 1955 to Aug 5, 1955, that I last saw the deceased alive on Aug, 1955, and that death occurred at 11:55 AM, from the causes and on the date stated above.

SIGNATURE M. D. ADDRESS Williamsport, Md. DATE SIGNED Aug 5 55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF Aug. 7, 1955 | NAME OF CEMETERY OR CREMATORY Riverview Cemetery | LOCATION (City, town, or county) (State) Williamsport, Md.

DATE REC'D BY LOCAL REGISTRAR Aug. 5, 1955 | REGISTRAR'S SIGNATURE Chas. H. Bowers | 24. FUNERAL DIRECTOR Edith V. Leaf | ADDRESS Williamsport, Md.

08120

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8113 **CERTIFICATE OF DEATH** Reg. Dist. No. 302

1. PLACE OF DEATH: COUNTY Washington MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown
LENGTH OF STAY (in this place) 45 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 158 S. Potomac St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Washington
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hagerstown
STREET ADDRESS (If rural give location) 158 S. Potomac St.

3. NAME OF DECEASED (Type or Print): (First) Lee (Middle) Roy (Last) Diffenderfer

4. DATE OF DEATH: (Month) 8 (Day) 22 (Year) 19 55

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Married

8. DATE OF BIRTH: June 24, 1896

9. AGE last birthday: 59 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Trainman

10B. KIND OF BUSINESS OR INDUSTRY: Penna RR

11. BIRTHPLACE (State or foreign country): Boyce Va.

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: William Lee Diffenderfer

14. MOTHER'S MAIDEN NAME: Florence Carpenter

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. 214-09-0089

17. INFORMANT & ADDRESS: Theresa Diffenderfer 158 S. Potomac St. Hagerstown, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

153X IMMEDIATE CAUSE (A) General Abdominal Cancer — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs

ANTECEDENT CAUSE (S) DUE TO (B) Primary Cancer Sigmoid Colon — 1 yr

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. 21E. INJURY OCCURRED While at work ☐ Not while at work ☐ 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1937, 19..., to 8/22/55, 19, that I last saw the deceased alive on 8/21/55, 19, and that death occurred at 1010A M, from the causes and on the date stated above.

SIGNATURE M. D. Karl Young ADDRESS Hagerstown Md. DATE SIGNED 8/23/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF Aug 25, 1955 — NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery — LOCATION (City, town, or county) (State) Hagerstown Md.

DATE REC'D BY LOCAL REGISTRAR Aug. 24 1955 — REGISTRAR'S SIGNATURE Chas. H. Roward

24. FUNERAL DIRECTOR Rest Haven Funeral Chapel Inc. ADDRESS Hagerstown Md.

VS. A15—10-53

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08121

CERTIFICATE OF DEATH

8114 Reg. Dist. No. 302

1. PLACE OF DEATH:
COUNTY WASHINGTON
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 HAGERSTOWN
LENGTH OF STAY (in this place) 9 YRS.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 81 WASHINGTON COUNTY HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE MARYLAND COUNTY WASHINGTON
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN
STREET ADDRESS (If rural give location) 435 ELIZABETH AVE.

3. NAME OF DECEASED: (Type or Print) (First) EMMA (Middle) MAE (Last) DILL

4. DATE OF DEATH: (Month) AUGUST (Day) 27 (Year) 19 55

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): WIDOWED

8. DATE OF BIRTH: 4/12/1888

9. AGE last birthday: 67 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: HOME

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN LEE RECHER

14. MOTHER'S MAIDEN NAME: OLIVE A. TOMS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) NO (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: NONE

17. INFORMANT & ADDRESS: MRS. VIOLET M. DAVIS HAGERSTOWN MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

585X

Immediate cause (a) Pulmonary embolus — Interval Between Onset And Death: 3 hrs

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
DUE TO (b) Chole cystitis, cholecystectomy
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Hypertension

19a. DATE OF OPERATION: 8/18/55 — 19b. MAJOR FINDINGS OF OPERATION: Chole lithiasis, chole cystitis, perforating gall bladder

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 15, 1955, to Aug 27, 1955, that I last saw the deceased alive on Aug 27, 1955, and that death occurred at 12.22 p.m. from the causes and on the date stated above.

SIGNATURE (Degree or title) Edwin R. D. Wallace MD — ADDRESS Hagerstown Md — DATE SIGNED 8/29/55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF 8/30/55 — NAME OF CEMETERY OR CREMATORY Rose Hill Cem. — LOCATION (City, town, or county) Hagerstown (State) Md.

DATE REC'D BY LOCAL REGISTRAR Aug. 29 1955 — REGISTRAR'S SIGNATURE Robert H. Bowers

24. FUNERAL DIRECTOR W. T. Norment — ADDRESS Hagerstown Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

08122

MARYLAND STATE DEPARTMENT OF HEALTH

8150 CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 30

MARGIN RESERVED FOR BINDING

PLEASE WRITE WITH UNFADING INK. Supply every item of information carefully. The correct answer to each question is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY: Washington — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Dam #5- Wmpst, Md. — LENGTH OF STAY (In this place): 4 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Potomac River

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: West Virginia — COUNTY: Berkeley
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Martinsburg, W. Va.
STREET ADDRESS (If rural, give location): 410 S. Tennessee Ave.

3. NAME OF DECEASED (Type or Print): (First) Dr. Douglas (Middle) Calvin (Last) Dirting

4. DATE OF DEATH: (Month) Aug. 17 (Day) (Year) 1955

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: June 8, 1917

9. AGE Last birthday: 38 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Dentist

10b. KIND OF BUSINESS OR INDUSTRY: Dentistry

11. BIRTHPLACE (State or foreign country): North Mountain, W. Va.

12. CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: George Lemuel Dirting

14. MOTHER'S MAIDEN NAME: Anna Gletner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): W.W.II

16. SOCIAL SECURITY No.: 028-16-7355

17. INFORMANT AND ADDRESS: Mrs. Douglas Calvin Dirting

18. MEDICAL CERTIFICATION — Martinsburg, W.Va.

19. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a): Suffocation due to drowning

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last: (b) (c)

20. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: none

19a. DATE OF OPERATION: none — 19b. MAJOR FINDINGS OF OPERATION: --

20. AUTOPSY? Yes ☐ No ☒

ACCIDENT, PRIMARY ☒ OR CONTRIBUTING, SUICIDE, HOMICIDE — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Potomac River — (CITY OR TOWN) near Dam #5 — (COUNTY) Williamsport — (STATE) Wash, Md.

TIME OF INJURY (Month) (Day) (Year) (Hour) 8-13-55 @10:30PM. DST — INJURY OCCURRED While at work ☐ Not while at work ☒

HOW DID INJURY OCCUR? Boat capsized while fishing

22. I, [illegible], that I took charge of the [illegible] described [illegible] Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence [illegible] Autopsy, Inspection [illegible], [illegible] last [illegible] on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐

SIGNATURE (Degree or Title): J. Robert Wells DEPUTY MEDICAL EXAM. WASH. CO., MD. — ADDRESS: N. Potomac St - Hagerstown, Md. — DATE SIGNED: 8-17-55

DISPOSITION: Burial — DATE OF BURIAL: August 19, 55 — CEMETERY OR CREMATORY: Hedgesville — LOCATION (City, town, or county): Hedgesville — (State): W.Va.

DATE RECEIVED BY LOCAL REGISTRAR'S SIGNATURE: Aug. 18-55 — E Lee McElroy

24. FUNERAL DIRECTOR: Howard K. Brown, Martinsburg, W. Va. — ADDRESS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08123

8151 CERTIFICATE OF DEATH Reg. Dist. No. 302-

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

1. PLACE OF DEATH
COUNTY Washington MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Leitersburg
LENGTH OF STAY (in this place) life
HOSPITAL OR INSTITUTION OR STREET ADDRESS Brook Lane Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED.
STATE Maryland COUNTY Washington
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN rural Hagerstown
STREET ADDRESS (If rural give location) RFD #4

3. NAME OF DECEASED: (Type or Print) (First) Lillian (Middle) Edna (Last) Faith

4. DATE OF DEATH: (Month) 8 (Day) 30 (Year) 1955

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Married
8. DATE OF BIRTH: Oct 1903
9. AGE last birthday: 51 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Knitter
10B. KIND OF BUSINESS OR INDUSTRY: Stocking Mfg.
11. BIRTHPLACE (State or foreign country): Broadfording
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Christopher Neibert
14. MOTHER'S MAIDEN NAME: Ella Kershner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT & ADDRESS: Lowell Faith Hagerstown, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Crushed thoracic accident — INTERVAL BETWEEN ONSET AND DEATH: 30 min.

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST

(B) DUE TO Arteriosclerosis, senile — 10 yrs.

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. , 1953 to Aug 30, 1955, that I last saw the deceased alive on July 31, 1955, and that death occurred at 4 20 PM, from the causes and on the date stated above.

SIGNATURE [signature] M.D. — ADDRESS 215 W. Washington — DATE SIGNED 8/31/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF 8/20/2/55 — NAME OF CEMETERY OR CREMATORY Broadfording Cemetery — LOCATION (City, town, or county) (State) Broadfording, Md.

DATE REC'D BY LOCAL REGISTRAR Sept. 2, 1953 — REGISTRAR'S SIGNATURE [signature]

24. FUNERAL DIRECTOR Scott F Linnich & Son — ADDRESS Fag. Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08124

8152 **CERTIFICATE OF DEATH** Reg. Dist. No. 303

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 5

1. PLACE OF DEATH.
COUNTY Washington MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Clear Spring
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Residence

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Washington
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clear Spring X
STREET ADDRESS (If rural give location) Mill St. 1

3. NAME OF DECEASED: (Type or Print) (First) Harry (Middle) Franklin (Last) Gernand

4. DATE OF DEATH: (Month) August (Day) 20, (Year) 1955

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: Jan. 19, 1931

9. AGE last birthday: 24 yrs. IF UNDER 1 YEAR: Months 7 Days 4 IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Service Station Attendant

10B. KIND OF BUSINESS OR INDUSTRY: Garage

11. BIRTHPLACE (State or foreign country): Clear Spring, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Harry Gernand

14. MOTHER'S MAIDEN NAME: Carmen Widmyer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. 217-28-5498

17. INFORMANT & ADDRESS: Ethel Widmyer. Clear Spring, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE 434.3

(A) DUE TO Acute Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH: Sudden

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(B) DUE TO Chr. Cardiac Hypertrophy — 2 years.

(C) This case was seen after death. Last attended was 2 years ago.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Signed by authority of Med. Examiner

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from . . . ., 19.. ., to . . . ., 19... , that I last saw the deceased alive on . . . 19 ..., and that death occurred at 6,45 P.M., from the causes and on the date stated above.

SIGNATURE M. D. David P. Brewer ADDRESS Clear Spring Md DATE SIGNED 8/22/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF Aug. 23, 1955 — NAME OF CEMETERY OR CREMATORY Rose Hill — LOCATION (City, town, or county) Clear Spring, (State) Md.

DATE REC'D BY LOCAL REGISTRAR 8-22-55 — REGISTRAR'S SIGNATURE Joseph W. Murray

24. FUNERAL DIRECTOR Adonis H. Rowland — ADDRESS Clear Spring Md.

MARYLAND STATE DEPARTMENT OF HEALTH

08125

2411 N. Charles Street, Baltimore

8115 # CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH
COUNTY Washington MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hagerstown
LENGTH OF STAY (in this place) 24 Hrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Wash. County Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY Washington
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hagerstown R # 4
(If rural, give location) ADDRESS Cearfoss

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month) (Day) (Year)
Owen	Franklin	Giniven	Aug. 4, 1955

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Mins.
Male	White	Single	Aug. 3, 1955	yrs.		24

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	Infant	Hagerstown, Md.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Ernest G. Giniven	Evelyn Giniven

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
	None	Ernest G. Giniven

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
7767 Immediate cause (a) Premature Birth	
Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (b)	
(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from ....., 19....., to ....., 19....., that I last saw the deceased alive on ....., 19....., and that death occurred at .....m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Paul Harrison M D

23. BURIAL, CREMATION / REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	8/4/55	Levels Meth Cemetery	Levels Hampshire Co. W.Va.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
Aug. 4 1955	Elias H Bowers	Andrew K. Coffman Hagerstown Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08126

8153 **CERTIFICATE OF DEATH** Reg. Dist. No. 307

1. PLACE OF DEATH:
COUNTY WASHINGTON MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X TREGO - RURAL
LENGTH OF STAY (In this place) 60 YEARS
HOSPITAL OR INSTITUTION OR STREET ADDRESS REEDYSVILLE MD. R.1

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY WASHINGTON
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN TREGO - RURAL
STREET ADDRESS (If rural give location) REEDYSVILLE MD. R.1

3. NAME OF DECEASED: (Type or Print) (First) WILLIAM (Middle) SEYMOUR (Last) GLOSS

4. DATE OF DEATH: (Month) AUGUST (Day) 22, (Year) 1955

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): SINGLE

8. DATE OF BIRTH: NOV. 22 - 1880

9. AGE last birthday: 74-9-0 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER

10B. KIND OF BUSINESS OR INDUSTRY: OWN FARM

11. BIRTHPLACE (State or foreign country): ANTIETAM WASH. Co. MD.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: GEORGE W. GLOSS

14. MOTHER'S MAIDEN NAME: MALINDA KEEDY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No.
(If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. NONE

17. INFORMANT & ADDRESS: MISS MAUDE GLOSS REEDYSVILLE MD. R.1.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

203X

IMMEDIATE CAUSE (A) Multiple myeloma

ANTECEDENT CAUSE (B) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH: 9 months

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: April, 1955

19B. MAJOR FINDINGS OF OPERATION: Biopsy of tumor of skull - multiple myeloma.

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/28/55, 19..., to 2/22/55, 19..., that I last saw the deceased alive on 8/20/55, 19..., and that death occurred at 9.15 P.M., from the causes and on the date stated above.

SIGNATURE W. A. Shealy M.D. ADDRESS Sharpsburg, Md. DATE SIGNED 8/24/55.

23. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL

DATE THEREOF: AUG. 25. 1955

NAME OF CEMETERY OR CREMATORY: ROHRERSVILLE CEMETERY

LOCATION (City, town, or county) (State): ROHRERSVILLE WASH. Co. MD.

DATE REC'D BY LOCAL REGISTRAR: Aug. 24 - 1955

REGISTRAR'S SIGNATURE: Tanner W. Reichard

24. FUNERAL DIRECTOR: WM. F. BAST AND SONS ADDRESS: BOONSBORO MD.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-55

08127

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

8116 CERTIFICATE OF DEATH

Reg. Dist. No. 307

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Washington — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hagerstown
LENGTH OF STAY (in this place) 1 month
HOSPITAL OR INSTITUTION OR STREET ADDRESS Washington County Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Wash.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hagerstown
STREET ADDRESS (If rural, give location) 111 Elizabeth St.

3. NAME OF DECEASED (Type or Print): (First) Charles (Middle) Monroe H. (Last) Holliday
4. DATE OF DEATH: (Month) Aug (Day) 11 (Year) 1955

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, ~~WIDOWED, DIVORCED~~ (Specify): single
8. DATE OF BIRTH: Jan 21 1888
9. AGE last birthday: 67 yrs. | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Foreman
10b. KIND OF BUSINESS/INDUSTRY: Pressure Boiler
11. BIRTHPLACE (State or foreign country): Hawkinstown, Va.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Homer Holliday
14. MOTHER'S MAIDEN NAME: Carrie Lee Fry.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 220-10-3521
17. INFORMANT AND ADDRESS: V. S. Dellinger Woodstock, Va.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

44 Y

Immediate cause (a) Nephrosclerosis with uremia — Interval between onset and death: unknown

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b)
(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: none
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): none
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 18 July, 1955, to 11 Aug, 1955, that I last saw the deceased alive on 10 Aug, 1955, and that death occurred at 8 30 A.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Frank E Brumback MD 11 Aug 55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: 8/12/55
NAME OF CEMETERY OR CREMATORY: Hawkinstown
LOCATION (City, town, or county) (State): Hawkinstown Va.

DATE REC'D BY LOCAL REG.: Aug. 11. 1955
REGISTRAR'S SIGNATURE: Ernest H Boerner
24. FUNERAL DIRECTOR: Fred W Kraus ADDRESS: Hagerstown, Md

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08128

8117

CERTIFICATE OF DEATH

Reg. Dist. No. 302

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-5

1. PLACE OF DEATH.
COUNTY Washington MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown
LENGTH OF STAY (in this place) 45 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 111 E. Hillcrest Road

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Md. COUNTY Washington
CITY (If outside corporate limits, write RURAL and give nearest town)
TOWN Hagerstown
STREET ADDRESS (If rural give location) 111 E. Hillcrest Road

3. NAME OF DECEASED: (Type or Print) (First) Dorothy (Middle) May (Last) Haines

4. DATE OF DEATH (Month) 8 (Day) 15 (Year) 1955

5. SEX: female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): married

8. DATE OF BIRTH: Dec. 24, 1907

9. AGE last birthday: 47 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): secreatry

10B. KIND OF BUSINESS OR INDUSTRY: M.P. Moller Co.

11. BIRTHPLACE (State or foreign country): Mineral, Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Harry E. Morgan

14. MOTHER'S MAIDEN NAME: Annie M. Spicer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. 060-14-1677

17. INFORMANT & ADDRESS. Roy I. Haines Hagerstown, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

175X

IMMEDIATE CAUSE (A) Generalized carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: About 2 yr

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. None.

19A. DATE OF OPERATION: Mar.10,1953.

19B. MAJOR FINDINGS OF OPERATION: Carcinoma of left ovary.

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug.6, 1955, to Aug.15, 1955, that I last saw the deceased alive on Aug.12, 1955, and that death occurred at 7:10A M, from the causes and on the date stated above.

SIGNATURE Ka Bell M. D. ADDRESS Hagerstown, Maryland DATE SIGNED Aug.16,1955

23. BURIAL, CREMATION, REMOVAL (SPECIFY) burial | DATE THEREOF 8-17-55 | NAME OF CEMETERY OR CREMATORY Rest Haven | LOCATION (City, town, or county) Hagerstown (State) Md.

DATE REC'D BY LOCAL REGISTRAR Aug.16.1955 | REGISTRAR'S SIGNATURE Chas. H. Bowers

24. FUNERAL DIRECTOR Fred W. Kraiss ADDRESS Hagerstown, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08129

8118 CERTIFICATE OF DEATH Reg. Dist. No. 302

1. PLACE OF DEATH.
COUNTY Washington MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown
LENGTH OF STAY (in this place) 1 week
HOSPITAL OR INSTITUTION OR STREET ADDRESS Washington Co. Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Wash.
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown
STREET ADDRESS (If rural give location) 13 W. Baltimore St.,

3. NAME OF DECEASED: (Type or Print) (First) Susie (Middle) Rebecca (Last) Haines

4. DATE OF DEATH: (Month) 8 (Day) 12 (Year) 19 55

5. SEX: female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): married

8. DATE OF BIRTH. June 28, 1870

9. AGE last birthday 85 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY: home

11. BIRTHPLACE (State or foreign country): Keysville, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Isiah Frock

14. MOTHER'S MAIDEN NAME: Sarah Whitmore

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. none

17. INFORMANT & ADDRESS: Mrs. George Diggs Hagerstown, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.0

IMMEDIATE CAUSE (A) Myocarditis (Chronic) Thrombosis — 9 days

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

DUE TO (B)

DUE TO (C) Arteriosclerotic Heart Dis. — 2 yrs

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.

21c. WHERE DID (City or town) (County) (State) INJURY OCCUR?

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/4/55, 19 , to 8/12, 1955, that I last saw the deceased alive on 8/12/55, 19 , and that death occurred at M, from the causes and on the date stated above.

SIGNATURE Dr. W. Reitz ADDRESS Hagerstown Md. DATE SIGNED 8/14/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) burial

DATE THEREOF 8-14-55

NAME OF CEMETERY OR CREMATORY Rose Hill

LOCATION (City, town, or county) Hagerstown (State) Md.

DATE REC'D BY LOCAL REGISTRAR Aug. 13 1955

REGISTRAR'S SIGNATURE Edward H. Bowers

24. FUNERAL DIRECTOR Fred W. Kraiss ADDRESS Hagerstown, Md.

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

8154

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

08130

Reg. Dist. No. 316

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age, if especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

1. PLACE OF DEATH: COUNTY WASHINGTON; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X RURAL; MARYLAND; LENGTH OF STAY (in this place) 7 MONTHS; HOSPITAL OR INSTITUTION OR STREET ADDRESS KEEDYSVILLE MD. R-1

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND; COUNTY WASHINGTON; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN MT. CARMEL - RURAL X; STREET ADDRESS (If rural, give location) KEEDYSVILLE MD. R-1

3. NAME OF DECEASED (Type or Print): (First) JONATHAN (Middle) CARNEY (Last) HARRELL

4. DATE OF DEATH: (Month) AUGUST (Day) 26 (Year) 1955

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): SINGLE

8. DATE OF BIRTH: SEPT-12-1950

9. AGE last birthday: 4-11-14 yrs. | If under 1 year: Months | Days | If under 24 hrs: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE

10b. KIND OF BUSINESS OR INDUSTRY: AT HOME

11. BIRTHPLACE (State or foreign country): KEEDYSVILLE WASH. Co. MD

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: CARNEY L. HARRELL

14. MOTHER'S MAIDEN NAME: MARY LEE HOSE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No | (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT AND ADDRESS: CARNEY L. HARRELL KEEDYSVILLE MD. R1

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Chopped Up in Ensilage Machine (Only remaining recognizable parts of body was one arm and one leg)

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

INTERVAL BETWEEN ONSET AND DEATH

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: none

19a. DATE OF OPERATION: none

19b. MAJOR FINDINGS OF OPERATION: -

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY: Farm

(CITY OR TOWN) Rural - Keedysville (COUNTY) Wash (STATE) Md.

TIME OF INJURY (Month) Aug. (Day) 26 (Year) '55 (Hour) 6 P.m. DST

INJURY OCCURRED While at work ☐ Not while at work ☒

HOW DID INJURY OCCUR? Fell in ensilage Machine

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE: S. Robert Wells M.D. (Degree or title) DEPUTY MEDICAL EXAM. WASH. CO., MD. ADDRESS: 115 N. Potomac Street-Hagerstown, Md. DATE SIGNED: 9-27-55

23. BURIAL, CREMATION, REMOVAL (Specify): BURIAL | DATE THEREOF: Aug. 29, 1955 | NAME OF CEMETERY OR CREMATORY: REST HAVEN CEMETERY | LOCATION (City, town, or county) (State): HAGERSTOWN MD.

DATE REC'D BY LOCAL REG.: Aug. 29, 1955 | REGISTRAR'S SIGNATURE: [illegible] | 24. FUNERAL DIRECTOR | ADDRESS: WM. F. BAST AND SONS BOONSBORO MD.

MARYLAND STATE DEPARTMENT OF HEALTH

8155

2411 N. Charles Street, Baltimore

08131

CERTIFICATE OF DEATH

Reg. Dist. No.....

Item 13, Film C187 9-28-55 et

1. PLACE OF DEATH: COUNTY Wash. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hagerstown Rural
LENGTH OF STAY (In this place) 3 mo.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Gateway Convalescent Home

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Pa. COUNTY Fulton
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN McConnellsburg
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Hammel (Middle) (Last) Harris

4. DATE OF DEATH: (Month) Aug (Day) 28. (Year) 1955

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: Nov 21, 1869

9. AGE last birthday: 85 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Blacksmith

10b. KIND OF BUSINESS OR INDUSTRY: Self.

11. BIRTHPLACE (State or foreign country): Franklin Co.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Sallylenn. Harris

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No

16. SOCIAL SECURITY NO.:

17. INFORMANT AND ADDRESS: Mrs Ruth Fittman, Needmore Pa.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

3-4)

Immediate cause (a) Cerebral Sclerosis — Interval between onset and death: 4 mo.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arterial Sclerosis — 5 yrs.

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 16, 1955, to Aug 28, 1955, that I last saw the deceased alive on Aug 27, 1955, and that death occurred at 12.45 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) David F. Brewer M.D. ADDRESS Clear Spring Md. DATE SIGNED 8/28/55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE: Aug. 31 55

NAME OF CEMETERY OR CREMATORY: Union

LOCATION (City, town, or county): Ayr Twp (State): Fulton, Pa.

DATE REC'D BY LOCAL REG.: Aug 28 1955

REGISTRAR'S SIGNATURE: Joseph W. Murray Local

24. FUNERAL DIRECTOR: T.M. Linniger ADDRESS: Mercersburg, Pa.

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08132

CERTIFICATE OF DEATH

8119

Reg. Dist. No. 302

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-[illegible]

I

1. PLACE OF DEATH:
COUNTY Washington
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown
MARYLAND LENGTH OF STAY (in this place) 8days
HOSPITAL OR INSTITUTION OR STREET ADDRESS 81 Wash. County Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Wash
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown
STREET ADDRESS (If rural give location) 311 Ridge Ave.

3. NAME OF DECEASED. (Type or Print) (First) Gary (Middle) Lee (Last) Hose

4. DATE OF DEATH (Month) Aug (Day) 12 (Year) 1955

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Single

8. DATE OF BIRTH: Aug. 4, 1955

9. AGE last birthday IF UNDER 1 YEAR Months -- Days 8 IF UNDER 24 HRS. Hours Min. -- yrs.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None

10B. KIND OF BUSINESS OR INDUSTRY: ----

11. BIRTHPLACE (State or foreign country) Hagerstown Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Russell Hose

14. MOTHER'S MAIDEN NAME: Hilda Shives

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. ---

17. INFORMANT & ADDRESS. Russell Hose Hag. Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE 757.1

(A) DUE TO Poly Cystic disease — INTERVAL BETWEEN ONSET AND DEATH Life

ANTECEDENT CAUSE (S):

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. None.

19A. DATE OF OPERATION None

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Birth 8-4-55, 19, to death 8-12-55, 19, that I last saw the deceased alive on 8-12-, 1955, and that death occurred at 8:40 P M, from the causes and on the date stated above.

SIGNATURE Robert L. Keedy M. D. ADDRESS Hagerstown Md DATE SIGNED 8-13-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

DATE THEREOF 8-13-55

NAME OF CEMETERY OR CREMATORY Church of God

LOCATION (City, town, or county) Broadfording Md. (State)

DATE REC'D BY LOCAL REGISTRAR Aug 13, 1955

REGISTRAR'S SIGNATURE A. Earl H. Bowers

24. FUNERAL DIRECTOR Scott F. Minnich & Son

ADDRESS Hag. Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08133

8156 CERTIFICATE OF DEATH Reg. Dist. No. ...

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-52

1. PLACE OF DEATH:
COUNTY Washington MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sharpsburg Md.
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Sharpsburg Md.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Washington
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SHARPSBURG Md. X
STREET ADDRESS (If rural give location) Sharpsburg Md.

3. NAME OF DECEASED: (Type or Print) (First) Minnie (Middle) Florence (Last) Jamison

4. DATE OF DEATH: (Month) Aug. (Day) 9 (Year) 1955

5. SEX: Female 6. COLOR OR RACE: White 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married 8. DATE OF BIRTH: June 8 1876 9. AGE last birthday 79 yrs. IF UNDER 1 YEAR Months 2 Days 0 IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Cumberland Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Merideth Grey
14. MOTHER'S MAIDEN NAME: Mary Gardner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) No
16. SOCIAL SECURITY NO. None
17. INFORMANT & ADDRESS: Mr. Joseph Jamison Sharpsburg Md

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 hour.

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO Hypertensive cardio-vascular disease 5 Yr.

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1950, 19....., to 8/9/55 19...., that I last saw the deceased alive on 8/6, 1955, and that death occurred at M, from the causes and on the date stated above.

SIGNATURE Walter H. Shea M.D. ADDRESS Sharpsburg, Md. DATE SIGNED August 10, 1955

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF Aug. 11-55
NAME OF CEMETERY OR CREMATORY Mt. View Cemetery
LOCATION (City, town, or county) (State) Sharpsburg Md.

DATE REC'D BY LOCAL REGISTRAR Aug. 10, 1955
REGISTRAR'S SIGNATURE E. G. Bayer

24. FUNERAL DIRECTOR ADDRESS Albert L. Leaf Williamsport Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

CERTIFICATE OF DEATH

8120

08134 302 304

Reg. Dist. No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

COUNTY Washington Md — STATE MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hagerstown — LENGTH OF STAY (in this place) 4 Hrs

HOSPITAL OR INSTITUTION OR STREET ADDRESS 81 Washington County Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Mayland Washington COUNTY

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Hancock

STREET ADDRESS (If rural give location) R F D 2

3. NAME OF DECEASED: (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH: (Month)	(Day)	(Year)
	William	Howard	Keefer	8	11	1935

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
M.	W	married	April 30 1887	68 yrs.	4			

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
		Fulton County Pa.	and A

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Emanuel Keefer	Margaret Zies

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
no no	205-10-8004	Mrs Nellie M Keefer RFD 2 Hancock Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Arteriosclerosis Cardio Vascular Renal DUE TO

(c)

Interval Between Onset And Death: (a) hours (b) years

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Emphysema Pulmonary & Pyelitis Ulcer

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURED While at Work ☐ Not While At Work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 8/11 ....., 19 35, to 8/11 ....., 19 35, that I last saw the deceased alive on 8/11 ....., 19 35, and that death occurred at 11:20 PM, from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
Howard N. Wolfe, M.D.	100 N. Potomac Hagerstown Md	8/12/35

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	8-14-35	Rehobeth Cemetery	Hancock Washington Md

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Aug. 16/1935	Chas H Bowers	Howard Johnson	Hancock Md

Rec'd from J. A. Hollar Hancock Md Loc Reg.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

08135

8121

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 302

1. PLACE OF DEATH: COUNTY Washington; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hagerstown; LENGTH OF STAY (In this place) 14 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Washington County Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Washington
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Boonsboro, X
STREET ADDRESS (If rural, give location) St. Paul Street 1

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month) (Day) (Year)
Fred	Atlee	Kephart	August 15 1955

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
Male	White	Married	Oct. 12, 1927	27 yrs.	10 / 3	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Electrician
10b. KIND OF BUSINESS OR INDUSTRY: Wyand Appliance Co.
11. BIRTHPLACE (State or foreign country): Boonsboro, Wash. Co. Md.
12. CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: Foster B. Kephart
14. MOTHER'S MAIDEN NAME: Effie Cline

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) Yes (If yes, give war or dates of service) W.W. II
16. SOCIAL SECURITY NO. 214-28-7325
17. INFORMANT AND ADDRESS: Mrs. Betty Kephart- Boonsboro, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
702 Immediate cause	(a)	acute bacterial endocarditis	1 mo
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	nephretic abscess	5 mos.
	(c)	multiple fractures vertebrae, multiple fractures carpal & tarsal bones	9 mos.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: --

19a. DATE OF OPERATION: 4/55-rt.nephredtomy - 19b. MAJOR FINDINGS OF OPERATION: peri-nephritic abscess
20. AUTOPSY? Yes ✓ No ☐

21. WAS DEATH DUE TO OR WAS CAUSE WAS CONTRIBUTING TO INJURY? PLACE (Home, farm, factory, street, office bldg., etc.): home
(CITY OR TOWN) Boonsboro (COUNTY) Washington (STATE) Md.
TIME OF INJURY (Month) (Day) (Year) (Hour) 12-1-54 10:30AM EST
INJURY OCCURRED While at work ✓ While not at work ☐
HOW DID INJURY OCCUR? Fell from television tower

22. I certify that I took charge of the remains described above, held an Autopsy ✓, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry find that said deceased died on the day stated above, and death in my opinion resulted from natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE (Degree or Title): E. Robert Mello M.D., DEPUTY MEDICAL EXAM. WASH. CO., MD.
ADDRESS: 115 N. Potomac St- Hagerstown, Md.
DATE SIGNED: 8-17-55

DISPOSITION: Burial
DATE: Aug. 18 '55
NAME OF CEMETERY OR CREMATORY: Boonsboro Cemetery
LOCATION (City, town, or county) (State): Boonsboro, Wash Co Md.

23. FILED BY LOCAL REGISTRAR'S SIGNATURE: Aug. 17, 1955 C. Chas. H. Boewer
24. FUNERAL DIRECTOR: Wm F. Bast & Sons - Boonsboro, Md.
ADDRESS

MARGIN RESERVED FOR BINDING

WRITE LEGIBLY WITH UNFADING INK. Supply every item of information carefully. The correct age especially important. Physicians: please write the causes of death clearly and legibly.

VS A1-A

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08136

8122 CERTIFICATE OF DEATH

Reg. Dist. No. 302

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:
COUNTY WASHINGTON
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN
LENGTH OF STAY (In This Place) 4 YRS.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 425 N. MULBERRY ST.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE MARYLAND
COUNTY WASHINGTON
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN
STREET ADDRESS (If rural give location) 425 N. MULBERRY ST.

3. NAME OF DECEASED: (Type or Print) (First) SARAH (Middle) VICTORIA (Last) KLINE

4. DATE OF DEATH: (Month) AUGUST (Day) 7 (Year) 1955

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): WIDOWED
8. DATE OF BIRTH: 8/9/1872
9. AGE Last birthday: 82 yrs.
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: HOME
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: DANIEL W. ROHRER
14. MOTHER'S MAIDEN NAME: MARY C. NELSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unk.) NO
(If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT & ADDRESS: MR. HARRY W. KLINE MAUGANSVILLE MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

154X

Immediate cause (a) CARCINOMATOSIS — Interval Between Onset And Death: UNKNOWN

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) CARCINOMA OF THE RECTUM — 3 YEARS

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. ARTERIOSCLEROTIC HEART DISEASE — 10 YRS

19a. DATE OF OPERATION: none.
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from MAR 12, 1945, to AUG. 7, 1955, that I last saw the deceased alive on July 31, 1955, and that death occurred at 3:30 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) Archie Robertson M.D. ADDRESS CLEAR SPRING, Md. DATE SIGNED AUG. 8, 1955

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF 8/9/55 — NAME OF CEMETERY OR CREMATORY Rose Hill Cem. — LOCATION (City, town, or county) (State) Hagerstown Md.

DATE REC'D BY LOCAL REGISTRAR Aug. 8, 1955 — REGISTRAR'S SIGNATURE Chest Board

24. FUNERAL DIRECTOR W. J. Rowland — ADDRESS Hagerstown, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 [illegible]

8123

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:
COUNTY Washington | MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hagerstown | LENGTH OF STAY (in this place) 62 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 611 W. Church St.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Wash.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hagerstown
STREET ADDRESS (If rural give location) 35 E. Franklin St.

3. NAME OF DECEASED: (Type or Print) (First) Beulah (Middle) Mabel (Last) Lehman

4. DATE OF DEATH (Month) Aug. (Day) 23 (Year) 19 55

5. SEX female | 6. COLOR OR RACE: white | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): widowed | 8. DATE OF BIRTH: Oct. 22, 1892 | 9. AGE last birthday 62 yrs | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) telephone opt. | 10B. KIND OF BUSINESS OR INDUSTRY: stocking mfg. | 11. BIRTHPLACE State or foreign country) Wilson, Md. | 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Joseph Trumpower

14. MOTHER'S MAIDEN NAME: Catherine Atherton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. 214-09-1422

17. INFORMANT & ADDRESS. Mrs. Darris Miller, Hagerstown, Md.

18. MEDICAL CERTIFICATION.

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

170X

IMMEDIATE CAUSE (A) Carcinoma of Breast — INTERVAL BETWEEN ONSET AND DEATH (a) two

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION 6-10-55 | 19B. MAJOR FINDINGS OF OPERATION Ca of breast (il) | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21B. PLACE OF INJURY (Home, farm, factor, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | 21E. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 1, 1955, to Aug 23, 1955 that I last saw the deceased alive on 9-23, 1955 and that death occurred at 1159 P M, from the causes and on the date stated above.

SIGNATURE Robert P. Conrad, M.D. | ADDRESS Hagerstown, Md | DATE SIGNED 8-24-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) burial | DATE THEREOF 8-26-55 | NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery | LOCATION (City, town, or county) (State) Hagerstown, Md.

DATE REC'D BY LOCAL REGISTRAR Aug 26 1955 | REGISTRAR'S SIGNATURE Chas H. Bowers

24. FUNERAL DIRECTOR Scott F. Minnich & Son | ADDRESS Hagerstown

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15—10-[illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08138

8124

CERTIFICATE OF DEATH

Reg. Dist. No. 302

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:

COUNTY: Washington — STATE: MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown

LENGTH OF STAY (in this place): 8years

HOSPITAL OR INSTITUTION OR STREET ADDRESS: 90 Bellevue County Home

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE: Maryland — COUNTY: Washington

CITY (If outside corporate limits, write RURAL and give nearest town) / TOWN: Hagerstown 03

STREET ADDRESS (If rural give location): Bellevue County Home

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH: (Month)	(Day)	(Year)
Margaret		Lizer	Aug.	2,	19 55

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Female	White	Widow	Jan. 11, 1881	74 yrs.	6	21		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):	10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Housewife	At Home	Williamsport, Md.	USA

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
John E. Wolfe	Laura Bowers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS:
No	None	George Wolfe Williamsport, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE: 428.0 (A) Arteriosclerotic Heart Disease

ANTECEDENT CAUSE (S) DUE TO:

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO

(C) Chronic Cholecystitis

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21E. INJURY OCCURRED While at work ☐ Not while at work ☐	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 5, 1953 to Aug. 2, 1955 that I last saw the deceased alive on Aug. 2, 1955 and that death occurred at 5:50 P.M. from the causes and on the date stated above.

SIGNATURE: Sidney Bonnerstein M. D. — ADDRESS: Hagerstown Md — DATE SIGNED: 8-3-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Aug. 5, 1955	Riverview Cemetery	Williamsport, Md.

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Aug. 3, 1955	Chas. H. Bowers	Albert L. Leaf	Williamsport, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10189

9228

CERTIFICATE OF DEATH

Reg. Dist. No. 303

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Washington MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hagerstown Rural
LENGTH OF STAY (in this place) 4 mo.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Gateway Convalescent Home

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY Wash.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Hancock
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) Harry (Middle) Elwood (Last) Manning

4. DATE OF DEATH: (Month) Aug (Day) 24 (Year) 1955

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH: Oct 9-1888

9. AGE Last birthday: 66 yrs. IF UNDER 1 YEAR: Months 10 Days 15 IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): merchant

10b. KIND OF BUSINESS OR INDUSTRY: merchant

11. BIRTHPLACE (State or foreign country): Fulton County Pa

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Thomas Manning

14. MOTHER'S MAIDEN NAME: Amelia Gummels

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) No

16. SOCIAL SECURITY NO.: 216-09-0047

17. INFORMANT & ADDRESS: Mrs Estella Manning Hancock Rt 1

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

231X

Immediate cause (a) Cerebral Hemorrhage — Interval Between Onset And Death: 5 months

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Arterial Sclerosis — 5 yrs.

DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐ (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 9, 1955, to Aug 24, 1955, that I last saw the deceased alive on Aug 24, 1955, and that death occurred at 4:55 P.M. from the causes and on the date stated above.

SIGNATURE (Degree or title) David R Brewer M.D. ADDRESS Clear Spring Md. DATE SIGNED 8/25/55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF 8-27-55 NAME OF CEMETERY OR CREMATORY Rondelay Cemetery LOCATION (City, town, or county) (State) Needmore Fulton Co Pa

DATE REC'D BY LOCAL REGISTRAR Aug 27-55 REGISTRAR'S SIGNATURE Leroy M Forkle (Deputy Clerk)

24. FUNERAL DIRECTOR Howard J Hose ADDRESS Hancock Md

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8157

CERTIFICATE OF DEATH

0813930-4

Reg. Dist. No.

Item 8, Film G185, 8-24-55 bh

1. PLACE OF DEATH:
COUNTY Washington MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X
LENGTH OF STAY (in this place) 50 Yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Home

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md Washington COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hancock Maryland X
STREET ADDRESS (If rural give location) Penna Ave

3. NAME OF DECEASED: (Type or Print) (First) Robert (Middle) John (Last) McCandlish

4. DATE OF DEATH: (Month) 8 (Day) 12 (Year) 19 55

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Oct 18 1880/1

9. AGE last birthday: 75 yrs. IF UNDER 1 YEAR: Months Days; IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Banker

10b. KIND OF BUSINESS OR INDUSTRY: Investment Banker

11. BIRTHPLACE (State or foreign country): Piedmount W.VA.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Upton B McCandlish

14. MOTHER'S MAIDEN NAME: Margret Landstreet

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes (If Yes, give war or dates of service) 1

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS: Mrs Jane G McCandlish Penna. Ave. Hancock Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1

Immediate cause (a) Coronary Occlusion

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Arteriosclerosis

DUE TO

(c)

Interval Between Onset And Death: Few Min.

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Probable carcinoma (gastric)

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-15, 1955, to 8-12, 1955, that I last saw the deceased alive on 8-12, 1955, and that death occurred at 8.40 P.M., from the causes and on the date stated above.

SIGNATURE Herbert R. Tobias (Degree or title) M.D. ADDRESS Hancock Md DATE SIGNED 8-13-55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF 8.15.55 NAME OF CEMETERY OR CREMATORY Presbyterian Cemetery LOCATION (City, town, or county) (State) Hancock Washington Md

DATE REC'D BY LOCAL REGISTRAR 8/15/55 REGISTRAR'S SIGNATURE J A Miller

24. FUNERAL DIRECTOR Howard F Gore ADDRESS Hancock md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

8125

CERTIFICATE OF DEATH

08140

Reg. Dist. No. 302

1. PLACE OF DEATH: COUNTY Washington; Hagerstown MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hagerstown; LENGTH OF STAY (in this place) 7 days; HOSPITAL OR INSTITUTION OR STREET ADDRESS Washington County Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Washington; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hancock; STREET ADDRESS (If rural, give location) R. 2

3. NAME OF DECEASED (Type or Print): (First) Edgar (Middle) Austin (Last) McKee

4. DATE OF DEATH: (Month) August (Day) 20 (Year) 1955

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Jan. 17 1883

9. AGE last birthday: 72 yrs. If under 1 year: Months 7, Days 3; If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farming

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): Whipscore Pa.

12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: John McKee

14. MOTHER'S MAIDEN NAME: Malinda Daniels

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY No.: None

17. INFORMANT AND ADDRESS: Dewey McKee Rt 2 Hancock, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

572.1

Immediate cause (a) acute diffuse peritonitis — Interval Between Onset and Death: 24 hrs

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) acute diverticulitis of sigmoid — 36 hrs.

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☑ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-19, 1955, to 8-20, 1955, that I last saw the deceased alive on 8-20, 1955, and that death occurred at 3.40 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

T H Brumbach M.D. 170 W Wash St Hagerstown Md 8/20/55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: 8/23/55

NAME OF CEMETERY OR CREMATORY: Methodist Cem.

LOCATION (City, town, or county) (State): Hancock, Md. R V

DATE REC'D BY LOCAL REG.: Aug 21 1955

REGISTRAR'S SIGNATURE: Chas A. Bowers

24. FUNERAL DIRECTOR: J. M. Kaufinger ADDRESS: Mercersburg, Pa.

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08141

8126

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH
COUNTY Washington MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Clear Spring
LENGTH OF STAY (In this place) Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS 81 Washington Co. Hospital

2 USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY Washington
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Clear Spring X
STREET ADDRESS (If rural give location) N. Martin St. 1

3. NAME OF DECEASED: (Type or Print) (First) R (Middle) Gegory Wayne (Last) McKee

4. DATE OF DEATH: (Month) Aug (Day) 17 (Year) 1955

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH July 6, 1952

9. AGE last birthday 3 years

IF UNDER 1 YEAR Months 1 Days 12

IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10B KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Washington County, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Samuel McKee

14. MOTHER'S MAIDEN NAME: Hildred Louise Rowland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) No

16. SOCIAL SECURITY NO. None

17. INFORMANT & ADDRESS John Samuel McKee Jr.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

2041

IMMEDIATE CAUSE (A) MASSIVE INTRACRANIAL HEMORRHAGE — INTERVAL BETWEEN ONSET AND DEATH: 5 HOURS

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) ACUTE MYELOGENOUS LEUKEMIA — 1 MONTH

DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. NONE

19A. DATE OF OPERATION: NONE

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D TIME (Month) (Day) (Year) (Hour) OF INJURY M.

21E INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from AUG 14 , 1955, to AUG 17 , 1955, that I last saw the deceased alive on AUG 17 , 19 55, and that death occurred at 8, 35 PM, from the causes and on the date stated above.

SIGNATURE Charles Robert Cohen M. D. ADDRESS CLEAR SPRING, MD. DATE SIGNED AUGUTS 18, 1955

23. BURIAL, CREMATION REMOVAL (SPECIFY) Burial | DATE THEREOF Aug. 20, 1955 | NAME OF CEMETERY OR CREMATORY St. Pauls Cem. | LOCATION (City, town, or county) (State) St. Pauls, Clear Spring, Md.

DATE REC'D BY LOCAL REGISTRAR Aug. 22 1955 | REGISTRAR'S SIGNATURE Chas H Bowers

24. FUNERAL DIRECTOR Adrian H. Rowland | ADDRESS Clear Spring, Md.

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

VS. A15—10-53

DR. SPRECHER
314 N. POTOMAC ST.
HAGERSTOWN

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15—10-58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08142

8127

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:
COUNTY WASHINGTON
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN
MARYLAND LENGTH OF STAY (in this place) 12 YEARS
HOSPITAL OR INSTITUTION OR STREET ADDRESS 861 MULBERRY AVE

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY WASHINGTON
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN HAGERSTOWN
STREET ADDRESS (If rural give location) 861 MULBERRY AVE.

3. NAME OF DECEASED: (Type or Print) FREEDA (First) MARIE (Middle) MULLENDORE (Last)

4. DATE OF DEATH: (Month) AUG. (Day) 20. (Year) 1955

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED
8. DATE OF BIRTH: JUNE 10 1909
9. AGE last birthday 46-2-10 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE
10B. KIND OF BUSINESS OR INDUSTRY: OWN HOME
11. BIRTHPLACE (State or foreign country): MONROE WASH. Co. MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: HARVEY DAVIS
14. MOTHER'S MAIDEN NAME: GERTRUDE GRUBER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No.
(If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. NONE
17. INFORMANT & ADDRESS: GAIL H. MULLENDORE 861 MULBERRY AVE HAGERSTOWN MD.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

154X
IMMEDIATE CAUSE
(A) Acute cystitis & pyelonephritis, Uremia — INTERVAL BETWEEN ONSET AND DEATH: 5 days

ANTECEDENT CAUSE (S)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.
DUE TO (B) Recurrent carcinoma of rectum with fistula pelvis and bladder, rectum, sigmoid, bladder, hepatic metastases — 10 months
DUE TO (C) and invasion of abdominal wall

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. None

19A. DATE OF OPERATION: 3/25/54
19B. MAJOR FINDINGS OF OPERATION: Carcinoma of rectum & extension thru wall of rectum
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/15, 1954, to 8-20, 1955 that I last saw the deceased alive on 8-20, 1955, and that death occurred at 6:30 A.M, from the causes and on the date stated above.

SIGNATURE: Omar D. Sprecher Jr. M.D.
ADDRESS: 314 N. Potomac St.
DATE SIGNED: 8/20/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL
DATE THEREOF: AUG. 22. 1955
NAME OF CEMETERY OR CREMATORY: REST HAVEN CEMETERY
LOCATION (City, town, or county) (State): HAGERSTOWN WASH. Co. MD

DATE REC'D BY LOCAL REGISTRAR: AUG. 20, 1955
REGISTRAR'S SIGNATURE: Chas. H. Bowers
24. FUNERAL DIRECTOR: WM. F BAST AND SONS
ADDRESS: BOONSBORO MD

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08143

8128 **CERTIFICATE OF DEATH** Reg. Dist. No. 582

1. PLACE OF DEATH
COUNTY Washington MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown
LENGTH OF STAY (in this place) 60 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Washington Co. Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Md. COUNTY Wash.
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown
STREET ADDRESS (If rural give location) 841 Lanvale St.

3. NAME OF DECEASED: (Type or Print) (First) Dessie (Middle) Viennie (Last) Myers

4. DATE OF DEATH. (Month) Aug. (Day) 28, (Year) 19 55

5. SEX: female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widowed

8. DATE OF BIRTH: Jan. 9, 1885

9. AGE last birthday: 70 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): house wife

10B. KIND OF BUSINESS OR INDUSTRY: own home

11. BIRTHPLACE (State or foreign country): Cavetown, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Jacob Johns

14. MOTHER'S MAIDEN NAME: Mary E. Sigler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. --

17. INFORMANT & ADDRESS: David Myers, Hagerstown, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.0

IMMEDIATE CAUSE (A) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 48 hours

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

DUE TO (B) Arteriosclerotic heart disease — Years.

DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug. 26, 1955; to Aug. 28, 1955; that I last saw the deceased alive on Aug. 28, 1955, and that death occurred at 11:30 P M, from the causes and on the date stated above.

SIGNATURE Edward Goodlin M. D. ADDRESS Hag. Md. DATE SIGNED 8/29/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) burial | DATE THEREOF Aug. 31, 55 | NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery | LOCATION (City, town, or county) (State) Hagerstown, Md.

DATE REC'D BY LOCAL REGISTRAR Aug. 30, 1955 | REGISTRAR'S SIGNATURE Chas. H. Bowers

24. FUNERAL DIRECTOR Scott F. Minnich & Son, ADDRESS Hagerstown

VS. A15 — 10 - 52

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08144

Item 9, Film G185 8-15-55 et

8129

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH
COUNTY WASHINGTON MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN
LENGTH OF STAY (in this place) 23 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS WASH. CO. HOSP.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY WASHINGTON
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FUNKSTOWN
STREET ADDRESS (If rural give location) 21 EAST BALTIMORE ST.

3. NAME OF DECEASED: (First) EDWARD (Middle) (Last) SCHUCK
4. DATE OF DEATH: (Month) 8 (Day) 5 (Year) 1955

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
MALE	WHITE	DIVORCED	SEPT. 23 1904	50 yrs.				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
INSPECTOR	FAIRCHILD AIRCRAFT	NEW JERSEY	U.S.A.

13. FATHER'S NAME: GEORGE SCHUCK
14. MOTHER'S MAIDEN NAME: MARIE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
NO	049-07-7471	MRS. RODELLA STERLING FUNKSTOWN, MD.

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE	(A) severe bronchial asthma	2yrs
ANTECEDENT CAUSE (S)	DUE TO (A) Bronchiectasis	1yr
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	DUE TO (B) Malignancy of bowel	10 mos
	(C) Arterio-Sclerotic myocardial heart disease	2yrs.
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.	21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While at work ☐ Not while at work ☐	21F. HOW DID INJURY OCCUR?
None M.		

22. I hereby certify that I attended the deceased from Oct ...., 19 42 to 8/5, 19 55 that I last saw the deceased alive on 8/5/55, 19 .., and that death occurred at 11:10 P.M. from the causes and on the date stated above.

SIGNATURE S. Robert Wells M. D. ADDRESS Hagerstown, Md. DATE SIGNED Aug 6-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
BURIAL	8/8/55	FUNKSTOWN	FUNKSTOWN, WASH. MD.

DATE REC'D BY LOCAL REGISTRAR Aug. 8, 1955 | REGISTRAR'S SIGNATURE Chas. H. Bowers

24. FUNERAL DIRECTOR ADDRESS FRED W. KRAISS HAGERSTOWN, MD.

VS. A15 — 10-58

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08145

Dr Brewer

8158

CERTIFICATE OF DEATH

Reg. Dist. No. 303

1. PLACE OF DEATH: COUNTY Washington MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 23 Hagerstown
LENGTH OF STAY (in this place) 6 Mos
HOSPITAL OR INSTITUTION OR STREET ADDRESS 9c Gateway Convalescent Home

2. USUAL RESIDENCE (HOME) OF DECEASED: Maryland STATE Washington COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown
STREET ADDRESS (If rural give location) 615 No. Mulberry St

3. NAME OF DECEASED: (Type or Print) (First) ESTA (Middle) MAY (Last) SHANK
4. DATE OF DEATH: (Month) Aug (Day) 3 (Year) 1955 19

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widpw
8. DATE OF BIRTH: Sept 24 1867
9. AGE last birthday 87 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10B. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country) near Myersville Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George W. Horine
14. MOTHER'S MAIDEN NAME: Adalne Harbaugh

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT & ADDRESS: Harry H. Shank

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

4214 IMMEDIATE CAUSE — (A) Chr. Endocarditis — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs.

ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.
DUE TO (B) Arterial Sclerosis — 10 yrs.
DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 1, 1955 to Aug 1, 1955, that I last saw the deceased alive on Aug 1, 1955, and that death occurred at 7.30 P.M, from the causes and on the date stated above.
SIGNATURE David R Brewer M. D. ADDRESS Clear Spring Md DATE SIGNED 8/9/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF 8/4/55
NAME OF CEMETERY OR CREMATORY Boonsboro Cemetery
LOCATION (City, town, or county) (State) Boonsboro Md.

DATE REC'D BY LOCAL REGISTRAR Aug 5 55
REGISTRAR'S SIGNATURE Leroy M Fockler (Deputy)
24. FUNERAL DIRECTOR Andrew K. Coffman ADDRESS Hagerstown Md.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 52

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08146

8130 CERTIFICATE OF DEATH Reg. Dist. No. 302

1. PLACE OF DEATH:
COUNTY WASHINGTON MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN
LENGTH OF STAY (in this place) 2 WEEKS
HOSPITAL OR INSTITUTION OR STREET ADDRESS WASH. Co. HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY WASHINGTON
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN MONROE - RURAL
STREET ADDRESS (If rural give location) BOONSBORO MD. R.1

3. NAME OF DECEASED: (Type or Print) (First) VERA (Middle) ELIZABETH (Last) SHIFLER

4. DATE OF DEATH: (Month) AUGUST (Day) 19 (Year) 1955

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED
8. DATE OF BIRTH: NOV. 30 - 1893
9. AGE last birthday 61-8-19 yrs
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE
10B. KIND OF BUSINESS OR INDUSTRY: OWN HOME
11. BIRTHPLACE (State or foreign country): MONROE WASH. Co. MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: CHARLES WUNAMAKER
14. MOTHER'S MAIDEN NAME: ELLA HOOVER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No. (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. NONE
17. INFORMANT & ADDRESS: RALPH SHIFLER BOONSBORO MD. R.1.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

234X IMMEDIATE CAUSE (A) Malnutrition and Pneumonia, hypostatic — INTERVAL BETWEEN ONSET AND DEATH: 3 wks 5 days

ANTECEDENT CAUSE (B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO (C) Ovarian tumor with generalized metastases — at least 1 yr

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: Nov 1955
19B. MAJOR FINDINGS OF OPERATION: Ovarian tumor c cystic sac metastases
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ..... to 8-19 19 55 that I last saw the deceased alive on 8-19 19 55, and that death occurred at 3:45 PM from the causes and on the date stated above.
SIGNATURE Robert J. Headle M. D. ADDRESS Hagerstown DATE SIGNED 8-20-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF Aug. 21, 1955
NAME OF CEMETERY OR CREMATORY Boonsboro Cemetery
LOCATION (City, town, or county) (State) Boonsboro Wash. Co. Md.

DATE REC'D BY LOCAL REGISTRAR Aug. 20, 1955
REGISTRAR'S SIGNATURE Chas. H. Bowers
24. FUNERAL DIRECTOR ADDRESS Wm. F. Bast and Sons Boonsboro Md

M
DR. HEADLE 318 N. PROSPECT ST HAGERSTOWN
I
VS. A15—10-53
MARGIN RESERVED FOR BINDING
PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-[illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08117

8159

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:
   COUNTY: Washington
   CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Hagerstown Rural
   MARYLAND
   LENGTH OF STAY (In this place): 6 years
   HOSPITAL OR INSTITUTION OR STREET ADDRESS: 08 R.F.D. #2

2. USUAL RESIDENCE (HOME) OF DECEASED:
   STATE: Maryland COUNTY: Washington
   CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Hagerstown Rural
   STREET ADDRESS (If rural give location): R.F.D. #2 X

3. NAME OF DECEASED: (First) CORA (Middle) LEE (Last) SHINGLETON

4. DATE OF DEATH: (Month) August (Day) 3 (Year) 1955

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: October 10, 1881

9. AGE (Last birthday) 73 yrs. IF UNDER 1 YEAR Months 9 Days 23 IF UNDER 24 HRS Hour Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Montgomery County Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Elizah Watkins

14. MOTHER'S MAIDEN NAME: Amanda Phillips

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): no (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: no

17. INFORMANT & ADDRESS: Mr. Riley B. Shingleton Hag. R.F.D. #2

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.0 IMMEDIAT CAUSE — (A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: aug 2 '55

ANTECEDENT CAUSE (S)

DISEASE OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST — (B) DUE TO Arteriosclerotic Heart D

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 15, 1955, to Aug. 3, 1955, that I last saw the deceased alive on Aug 3, 1955, and that death occurred at 11 A M, from the causes and on the date stated above.

SIGNATURE: Sidney Rosenstein M. D. ADDRESS: Hagerstown Md DATE SIGNED: 8-3-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

DATE THEREOF: 8/5/1955

NAME OF CEMETERY OR CREMATORY: Shankstown Church Cemetery

LOCATION (City, town, or county) (State): Shankstown, Maryland

DATE REC'D BY LOCAL REGISTRAR: Aug 4, 1955

REGISTRAR'S SIGNATURE: [illegible]

24. FUNERAL DIRECTOR: C. M. Suter & Sons ADDRESS: Hagerstown, Maryland

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08148

8160 **CERTIFICATE OF DEATH** Reg. Dist. No. 381

1. PLACE OF DEATH. COUNTY Washington MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Williamsport
LENGTH OF STAY (in this place) 5 Mo.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Williamsport Sanitarium 1540 Antietam St, Williamsport

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Washington
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown 03
STREET ADDRESS (If rural, give location) 208 W. Irving St. 1305 @ 3 P.m.

3. NAME OF DECEASED: (First) Mary (Middle) C. (Last) Shoemaker
4. DATE OF DEATH: (Month) August (Day) 19 (Year) 1955
5. SEX: Female 6. COLOR OR RACE: White 7. ~~SINGLE, MARRIED~~, WIDOWED, ~~DIVORCED~~ (Specify):
8. DATE OF BIRTH: July 28, 1862
9. AGE last birthday 93 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Franklin Co., Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Hugh Boyd Craig.
14. MOTHER'S MAIDEN NAME: Martha Agnes Orr

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No
16. SOCIAL SECURITY NO. None
17. INFORMANT & ADDRESS: Mrs. Geo. C. Stauffer, Hagerstown Md

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
933.0 IMMEDIATE CAUSE	(A) Fracture left femur	8 mos
ANTECEDENT CAUSE (S)	DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	(B) DUE TO (Arteriosclerotic heart disease	10 years)
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Generalized arteriosclerosis		—

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☑ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY Home
21C. WHERE DID INJURY OCCUR? (City or town) Hagerstown (County) Washington (State) Md.
21D. TIME OF INJURY (Month) Dec (Day) 21 (Year) 1954 (Hour) 6 P.M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☑
21F. HOW DID INJURY OCCUR? Lost balance & fell on bedroom floor

22. I hereby certify that I attended the deceased from Dec. 21, 1954, to Aug. 19, 1955, that I last saw the deceased alive on Aug. 18, 1955, and that death occurred at 3:30 P.M., from the causes and on the date stated above.
SIGNATURE R. S. Stauffer M. D. ADDRESS Hagerstown, Md. DATE SIGNED Aug. 19, 1955

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation
DATE THEREOF 8/21/1955
NAME OF CEMETERY OR CREMATORY Lee's Crematory
LOCATION (City, town, or county) (State) Washington, District of Columbia

DATE REC'D BY LOCAL REGISTRAR Aug. 20, 1955
REGISTRAR'S SIGNATURE E Lee McElroy
24. FUNERAL DIRECTOR Harold M. Zimmerman ADDRESS Greencastle, Pa

VS. A15—10-52

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

no 1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08149

8131 CERTIFICATE OF DEATH Reg. Dist. No. 302

1. PLACE OF DEATH:
COUNTY WASHINGTON
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN
LENGTH OF STAY (in this place) LIFE
HOSPITAL OR INSTITUTION OR STREET ADDRESS WASHINGTON COUNTY HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY WASHINGTON
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN
STREET ADDRESS (If rural give location) 351 S. CANNON AVE.

3. NAME OF DECEASED: (Type or Print) (First) KAREN (Middle) LYNNE (Last) SIRBAUGH

4. DATE OF DEATH: (Month) AUGUST (Day) 28 (Year) 1955

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. (SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Infant
8. DATE OF BIRTH: 8/28/1955
9. AGE last birthday: yrs.
IF UNDER 1 YEAR: Months, Days
IF UNDER 24 HRS.: Hours, Min. 20

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): INFANT
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: HARRY EUGENE SIRBAUGH
14. MOTHER'S MAIDEN NAME: TERESA E. BEAVER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) NO (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.: NONE
17. INFORMANT & ADDRESS: MR. HARRY E. SIRBAUGH HAGERSTOWN MD.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH
Immediate cause 776X
(a) Failure of heat regulation DUE TO
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
(b) Prematurity DUE TO
(c)
Interval Between Onset And Death: Hours Same

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from birth, 19 ..., to death, 19 ..., that I last saw the deceased alive on 8-28, 1955, and that death occurred at 6.50 AM from the causes and on the date stated above.
SIGNATURE (Degree or title) Robert T. Keadle M.D.
ADDRESS Hagerstown
DATE SIGNED 8-29-55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF 8/29/55
NAME OF CEMETERY OR CREMATORY Rose Hill Cem.
LOCATION (City, town, or county) (State) Hagerstown Md.
DATE REC'D BY LOCAL REGISTRAR Aug. 29. 1955
REGISTRAR'S SIGNATURE Charles Bowers
24. FUNERAL DIRECTOR W. T. Norment, Hagerstown, Md.
ADDRESS

21 5 x 5 x 1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

No 2

08150

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8132 CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:
COUNTY WASHINGTON
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN
LENGTH OF STAY (in this place) LIFE
HOSPITAL OR INSTITUTION OR STREET ADDRESS WASHINGTON COUNTY HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY WASHINGTON
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN
STREET ADDRESS (If rural give location) 351 S. CANNON AVE

03 / 1 / 81

3. NAME OF DECEASED: (Type or Print) (First) SHARON (Middle) LEE (Last) SIRBAUGH

4. DATE OF DEATH: (Month) AUGUST (Day) 28 (Year) 19 55

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Infant

8. DATE OF BIRTH: 8/28/1955

9. AGE last birthday: yrs. IF UNDER 1 YEAR: Months Days; IF UNDER 24 HRS.: Hours Min. 18

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): INFANT

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: HARRY EUGENE SIRBAUGH

14. MOTHER'S MAIDEN NAME: TERESA E. BEAVER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) NO (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: NONE

17. INFORMANT & ADDRESS: MR. HARRY E. SIRBAUGH

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) 776X Failure of heat regulation DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Prematurity (5½ mo) DUE TO

(c)

Interval Between Onset And Death: 1/2 hr / Same

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☒

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from birth, 19..., to death, 19..., that I last saw the deceased alive on 8-28, 19 55, and that death occurred at 6.58 AM from the causes and on the date stated above.

SIGNATURE (Degree or title) Robert T. Keedy MD ADDRESS Hagerstown DATE SIGNED 8-29-55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF 8/29/55 NAME OF CEMETERY OR CREMATORY Rose Hill Cem. LOCATION (City, town, or county) Hagerstown (State) Md.

DATE REC'D BY LOCAL REGISTRAR Aug. 29 1955 REGISTRAR'S SIGNATURE Chas. H. Bowers

24. FUNERAL DIRECTOR E. J. Normoyle ADDRESS Hagerstown Md.

2185x54x40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08151

8133 CERTIFICATE OF DEATH Reg. Dist. No. 302

1. PLACE OF DEATH:
COUNTY Washington
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hagerstown
LENGTH OF STAY (In this place) 1 day
HOSPITAL OR INSTITUTION OR STREET ADDRESS Carlock Memorial Home

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Washington
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hagerstown
STREET ADDRESS (If rural give location) 822 Pine Street

3. NAME OF DECEASED: (First) MARGARET (Middle) MAE (Last) SNYDER
4. DATE OF DEATH: (Month) August (Day) 16 (Year) 1955
5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed
8. DATE OF BIRTH: August 27, 1876
9. AGE last birthday: 78 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Housework
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Martinsburg, West Virginia
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: Joseph Byers
14. MOTHER'S MAIDEN NAME: Anna E. Ford
15. WAS DECEASED EVER IN U.S ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT & ADDRESS: Mrs. Anna E. Wolfe Hagerstown, Maryland

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Generalized Arteriosclerosis — Interval Between Onset And Death: 4 yr

Antecedent causes (s) Diseases or conditions, If any, giving rise to the above cause stating the underlying cause last. DUE TO (b) Arteriosclerotic Heart Disease — 1 yr

DUE TO (c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 15, 1955, to Aug. 16, 1955, that I last saw the deceased alive on Aug. 16, 1955, and that death occurred at 6 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
[signature] MD Hagerstown Md 8/11/55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF 8/19/55 NAME OF CEMETERY OR CREMATORY Riverview Cemetery LOCATION (City, town, or county) (State) Williamsport Maryland

DATE REC'D BY LOCAL REGISTRAR Aug. 18, 1955 REGISTRAR'S SIGNATURE [signature]

24. FUNERAL DIRECTOR C. M. Suter & Sons ADDRESS Hagerstown, Maryland

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

08152

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8134 **CERTIFICATE OF DEATH** Reg. Dist. No. 302

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-52

1. PLACE OF DEATH
COUNTY WASHINGTON MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN
LENGTH OF STAY (in this place) 37 YEARS
HOSPITAL OR INSTITUTION OR STREET ADDRESS 432 GEORGE ST.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY WASHINGTON
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN HAGERSTOWN
STREET ADDRESS (If rural give location) 432 GEORGE ST.

3. NAME OF DECEASED: (Type or Print) (First) LILLIAN (Middle) M, (Last) STATLER

4. DATE OF DEATH: (Month) 8 (Day) 6 (Year) 19 55

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): WIDOWED

8. DATE OF BIRTH: OCT, 7, 1872

9. AGE last birthday: 82 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWORK

10B. KIND OF BUSINESS OR INDUSTRY: OWN HOME

11. BIRTHPLACE (State or foreign country): PENNA.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: CHRISTIAN MYERS

14. MOTHER'S MAIDEN NAME: LEAH WINGER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) NO (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. NONE

17. INFORMANT & ADDRESS. MR. ROMAN STATLER HAGERSTOWN, MD.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

422.1
IMMEDIATE CAUSE (A)

ANTECEDENT CAUSE (B) DUE TO arterio sclerotic myocardial heart disease

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO with myocardial failure grade IV 4yrs

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) None M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased ~~from~~ AUG. 6, 1955, to , 19.., that I last saw the deceased alive on , 1955, and that death occurred at 8 P. M, from the causes and on the date stated above.

SIGNATURE S. Robert Wells M. D. ADDRESS 125 N. POTOMAC, HAGERSTOWN DATE SIGNED 8/8/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL DATE THEREOF 8/9/55 NAME OF CEMETERY OR CREMATORY REST HAVEN CEMETERY LOCATION (City, town, or county) (State) HAGERSTOWN, MD.

DATE REC'D BY LOCAL REGISTRAR Aug. 9, 1955 REGISTRAR'S SIGNATURE Chas. H. Bowers

24. FUNERAL DIRECTOR FRED W. KRAISS ADDRESS HAGERSTOWN, MD.

08153

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Dr. Robt. Campbell 8185

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:
COUNTY Washington MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown
LENGTH OF STAY (In this place) 10 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Washington Co. Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Washington
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown
STREET ADDRESS (If rural give location) 144 S. Mulberry St.

3. NAME OF DECEASED: (Type or Print) (First) OTHELIA (Middle) MAY (Last) STOUFFER

4. DATE OF DEATH: (Month) Aug. (Day) 17, (Year) 1955

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH: Aug. 7, 1884

9. AGE last birthday: 71 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Spielmans Sta., Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Aaron C. Middlekauff

14. MOTHER'S MAIDEN NAME: Laura Eakle

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) ---

16. SOCIAL SECURITY NO. None

17. INFORMANT & ADDRESS: Mr. Clarence W. Stouffer

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Coronary Artery Sclerosis — INTERVAL BETWEEN ONSET AND DEATH: 1 yr

ANTECEDENT CAUSE (B) DUE TO Generalized Arteriosclerosis — 10 yr

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1955 to Aug 17, 1955, that I last saw the deceased alive on Aug 17, 1955, and that death occurred at 2:15 P.M., from the causes and on the date stated above.

SIGNATURE Robert V. Campbell M. D. ADDRESS Hagerstown DATE SIGNED 8/19/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF 8-20-55 — NAME OF CEMETERY OR CREMATORY Bakersville Cemetery — LOCATION (City, town, or county) (State) Bakersville, Md.

DATE REC'D BY LOCAL REGISTRAR Aug. 20, 1955 — REGISTRAR'S SIGNATURE Chas. H. Boerner

24. FUNERAL DIRECTOR ADDRESS Andrew K. Coffman-Hagerstown, Md.

VS. A15—10-52

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08154

CERTIFICATE OF DEATH

Reg. Dist. No. 301

8161

1. PLACE OF DEATH: COUNTY Washington MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Williamsport, Md. LENGTH OF STAY (In this place) 5yrs 4mos 2 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Williamsport Sanitarium 154 N. Artz Ave St Williamsport, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Wa
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sharpsburg, Md. X
STREET ADDRESS (If rural give location) Route #1

3. NAME OF DECEASED: (First) Benjamin (Middle) (Last) Swain

4. DATE OF DEATH: (Month) Aug. 8, (Day) (Year) 1955

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed
8. DATE OF BIRTH: Aug 17, 1866
9. AGE last birthday: 88 yrs
IF UNDER 1 YEAR: Months 11 Days 21
IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10B. KIND OF BUSINESS OR INDUSTRY: Farm Owner
11. BIRTHPLACE (State or foreign country): Sharpsburg, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Benjamin Swain
14. MOTHER'S MAIDEN NAME: Elizabeth Boyer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) No
16. SOCIAL SECURITY NO. None
17. INFORMANT & ADDRESS: Mr. E. Lester Swain Williamsport, Maryland.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH
7821.4 IMMEDIATE CAUSE (A) Acute Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 2 days
ANTECEDENT CAUSE (S) DUE TO
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Cerebral Vascular Accident — 7 yrs ago

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/2 ..., 19 54, to 8 Aug ..., 19 55, that I last saw the deceased alive on 7 Aug ..., 19 55, and that death occurred at 7:26 PM, from the causes and on the date stated above.
SIGNATURE Lawrence M. D. ADDRESS Williamsport Md DATE SIGNED Aug 1955

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF Aug. 10, 1955
NAME OF CEMETERY OR CREMATORY Mt. View Cemetery
LOCATION (City, town, or county) (State) Sharpsburg, Maryland.

DATE REC'D BY LOCAL REGISTRAR Aug 9-1955
REGISTRAR'S SIGNATURE G. Lee McElroy
24. FUNERAL DIRECTOR ADDRESS Albert L. Leaf Williamsport, Md.

VS. A15—10-5

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8136 **CERTIFICATE OF DEATH**

08155

Reg. Dist. No. 303

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians—please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH.
COUNTY Washington MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown
LENGTH OF STAY (in this place) 5 Weeks
HOSPITAL OR INSTITUTION OR STREET ADDRESS 21 Gateway Nursing Home

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Penna. COUNTY Franklin
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Waynesboro R. D. 1
STREET ADDRESS (If rural give location) Rural 7 x 3

3. NAME OF DECEASED: (Type or Print) (First) Lewis (Middle) Edmund (Last) Tosten

4. DATE OF DEATH: (Month) Aug. (Day) 22 (Year) 1955

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Widowed

8. DATE OF BIRTH: July 9, 1872

9. AGE last birthday: 83 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10B. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (State or foreign country): Penn.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry Tosten

14. MOTHER'S MAIDEN NAME: Barbara E. Hoover

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. 217-10-2532

17. INFORMANT & ADDRESS: Mr John Tosten. Waynesboro, R.D.1

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

41 X IMMEDIATE CAUSE (A) Lobar Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 24 hours

ANTECEDENT CAUSE (S) DUE TO (B) Arterial Sclerosis — 10 yrs

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Cerebral Sclerosis — 3 mo

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 1, 1955, to Aug. 22, 1955, that I last saw the deceased alive on Aug 22, 1955, and that death occurred at 6.30 P.M., from the causes and on the date stated above.

SIGNATURE David P. Brewer M.D. ADDRESS Clear Spring Md DATE SIGNED 8/23/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Aug. 25, 1955	Brownville Cem.	Chambersburg, Pa.

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Aug 24-1955	Joseph W. Munay Local	Walter Grove.	Waynesboro, Pa.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08154

8162 CERTIFICATE OF DEATH Reg. Dist. No. 304

1. PLACE OF DEATH:
COUNTY Washington MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Hancock
LENGTH OF STAY (in this place) 4 Hrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland Washington COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Hancock Md. X
STREET ADDRESS (If rural give location) /

3. NAME OF DECEASED: (Type or Print) (First) Rance (Middle) Russell (Last) Trail
4. DATE OF DEATH: (Month) 8. (Day) 15. (Year) 19 55

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH: Aug. 18. 1898
9. AGE last birthday: 56 yrs. IF UNDER 1 YEAR: Months 11 Days 28 IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: Labor
10b. KIND OF BUSINESS OR INDUSTRY: Tree Triming
11. BIRTHPLACE (State or foreign country): Allegany County Md.
12. CITIZEN OF WHAT COUNTRY? U.S .A.

13. FATHER'S NAME: Charles Trail
14. MOTHER'S MAIDEN NAME: Emma Bell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) No
16. SOCIAL SECURITY NO.: 21[illegible]-18-7381
17. INFORMANT & ADDRESS: Robert F Trail 105 Carson Rd. Turtle Creek Penn

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH
Immediate cause (a) 42[illegible] DUE TO Coronary Thrombosis — Interval Between Onset And Death unknown
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) DUE TO
(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 15, 1955, to Aug 15, 1955, that I last saw the deceased alive on Aug 15, 1955, and that death occurred at 302 PM, from the causes and on the date stated above.
SIGNATURE (Degree or title) H M Thapper MD ADDRESS Hancock Md DATE SIGNED 8/16/55

23. BURIAL, CREMATION, REMOVAL, (Specify) Burial DATE THEREOF 8.18.55 NAME OF CEMETERY OR CREMATORY Piney Plains Md LOCATION (City, town, or county) (State) Allegany Maryland.
DATE REC'D BY LOCAL REGISTRAR 8/17/55 REGISTRAR'S SIGNATURE J A Miller
24. FUNERAL DIRECTOR Howard F Stone ADDRESS Hancock md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08157

8137

CERTIFICATE OF DEATH

Dr E. W. Ditto Jr

Reg. Dist. No. 302

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-55

1. PLACE OF DEATH: COUNTY Washington MARYLAND; CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown; LENGTH OF STAY (in this place) 3 Hrs; HOSPITAL OR INSTITUTION OR STREET ADDRESS 81 Wash. County Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Penna COUNTY Fulton; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Big Cove Tannery 75 X - 5; STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (First) BERTIE (Middle) ALICE (Last) TRUE

4. DATE OF DEATH: (Month) August (Day) 6 (Year) 1955

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH: May 3 1892

9. AGE last birthday: 63 yrs. IF UNDER 1 YEAR: Months, Days; IF UNDER 24 HRS.: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer Cannery Retired

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Artemis Bedford Co Pa.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Solomon Smith

14. MOTHER'S MAIDEN NAME: Ellen Wilson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) No

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS: Mrs Helen DeLanny

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

4.30.2

IMMEDIATE CAUSE (A) Cerebral Arterio Sclerosis

DUE TO

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-1-55, to 8-6-55, that I last saw the deceased alive on 8-6-55, and that death occurred at 9:40 M, from the causes and on the date stated above.

SIGNATURE M. D. ADDRESS DATE SIGNED 8/6/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial; DATE THEREOF 8-8-55; NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery; LOCATION (City, town, or county) (State) Hagerstown Md.

DATE REC'D BY LOCAL REGISTRAR Aug 8, 1955; REGISTRAR'S SIGNATURE Chas H Bowers

24. FUNERAL DIRECTOR Andrew K. Coffman ADDRESS Hagerstown Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

B163 Item 9, Film 185 8-22-55 et

CERTIFICATE OF DEATH

08158

Reg. Dist. No. 30

1. PLACE OF DEATH:
COUNTY Washington MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Downsville
LENGTH OF STAY (in this place) 74 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Downsville Md.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Washington
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Downsville Md.
STREET ADDRESS (If rural give location) Downsville Md.

3. NAME OF DECEASED: (Type or Print) (First) John (Middle) (Last) Waffensmith

4. DATE OF DEATH (Month) Aug. (Day) 14 (Year) 1955

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Widowed

8. DATE OF BIRTH: Oct. 5 1881

9. AGE last birthday 73 yrs. IF UNDER 1 YEAR Months 10 Days 8 IF UNDER 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life. Retired if retired) Ret'd Stone Mason

10B. KIND OF BUSINESS OR INDUSTRY: Stone Mason

11. BIRTHPLACE (State or foreign country): Downsville Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Waffensmith

14. MOTHER'S MAIDEN NAME: Elizabeth Myers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) No

16. SOCIAL SECURITY NO. None

17. INFORMANT & ADDRESS: Name changed legally Mr. Rene Smith Downsville Md. (Son)

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1
IMMEDIATE CAUSE (A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 day

ANTECEDENT CAUSE (S)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.
DUE TO (B)
DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/13/55 19..., to 8/14/55 19..., that I last saw the deceased alive on 8/14/55 19..., and that death occurred at 1 P.M., from the causes and on the date stated above.

SIGNATURE Ralph L. Young M.D. ADDRESS Williamsport Md. DATE SIGNED 8/15/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF Aug. 17-55 — NAME OF CEMETERY OR CREMATORY Manor Cemetery — LOCATION (City, town, or county) Near Tilghmanton Md. (State)

DATE REC'D BY LOCAL REGISTRAR Aug. 15-1955 — REGISTRAR'S SIGNATURE C Lee McElroy

24. FUNERAL DIRECTOR Albert L. Leaf — ADDRESS Williamsport Md.

VS. A15—10-55

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08159

8138

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:
COUNTY WASHINGTON
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN
MARYLAND
LENGTH OF STAY (in this place) 7 YRS.
HOSPITAL OR INSTITUTION OR STREET ADDRESS EARLOCK MEM. CONV. HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND
COUNTY WASHINFTON
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN
C3
STREET ADDRESS (If rural give location) 912 POTOMAC AVE.

3. NAME OF DECEASED: (Type or Print) (First) BERTINE (Middle) E. (Last) WESTON

4. DATE OF DEATH: (Month) AUGUST (Day) 10 (Year) 19 55

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH: 3/31/1898

9. AGE last birthday: 57 yrs.
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): RETIRED EDITOR

10b. KIND OF BUSINESS OR INDUSTRY: MAGAZINE

11. BIRTHPLACE (State or foreign country): NEW YORK

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: WILLIAM S. WESTON

14. MOTHER'S MAIDEN NAME: MINNIE BRUCE

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) NO
(If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: MR. ORVILLE WESTON HAGERSTOWN MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset And Death
Immediate cause	(a) 443X	
DUE TO		
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.	(b) arcular hypertension	15yrs
DUE TO	cerebral hemorrhage	12 yrs
	(c) arterio sclerotic myocardial heart disease	6yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) None m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-9, 1949, to 8-10, 19 55, that I last saw the deceased alive on 8-10, 19 55, and that death occurred at 8:35 PM, from the causes and on the date stated above.

SIGNATURE (Degree or title) Robert Wells M.D. ADDRESS Hagerstown, Md. DATE SIGNED Aug. 11. 55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF 8/14/55 NAME OF CEMETERY OR CREMATORY Fairview Cem. LOCATION (City, town, or county) Dunkable-Tarps Corner (State) Essex Co.

DATE REC'D BY LOCAL REGISTRAR Aug. 11. 1955 REGISTRAR'S SIGNATURE Chas. H. Bowers

24. FUNERAL DIRECTOR W. T. Norment ADDRESS Hagerstown, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

[illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08160

8139

CERTIFICATE OF DEATH

Reg. Dist. No. 1302

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-5

1. PLACE OF DEATH:
COUNTY Washington MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Md.
LENGTH OF STAY (in this place) 4 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Washington County Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Washington
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport X
STREET ADDRESS (If rural give location) #1 Fenton Ave.

3. NAME OF DECEASED: (Type or Print) (First) Edna (Middle) Pearl (Last) Whittington

4. DATE OF DEATH: (Month) Aug. (Day) 19 (Year) 1955

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: Aug. 1 1894

9. AGE last birthday: 61 yrs. IF UNDER 1 YEAR, Months 0 Days 18 IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Hagerstown Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Libni Mowen

14. MOTHER'S MAIDEN NAME: Virginia Carbaugh

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) No

16. SOCIAL SECURITY NO: None

17. INFORMANT & ADDRESS: 878 Va. Ave. Robert M. Whittington Hagerstown Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1
IMMEDIATE CAUSE (A) Coronary Thrombosis

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH: 1 Day

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 5 19..., to Aug 19 19..., that I last saw the deceased alive on Aug 19 19..., and that death occurred at 4 P M, from the causes and on the date stated above.

SIGNATURE M. D. ADDRESS Williamsport Md. DATE SIGNED Aug 22 55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

DATE THEREOF Aug. 22-1955

NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery

LOCATION (City, town, or county) (State) Williamsport Md.

DATE REC'D BY LOCAL REGISTRAR Aug. 22 1955

REGISTRAR'S SIGNATURE Chas H. Bowers

24. FUNERAL DIRECTOR ADDRESS Albert L. Leaf Williamsport Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 (1955)

8140

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:
COUNTY Washington MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown
LENGTH OF STAY (in this place) 4 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS 81 Washington County Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Washington
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hagerstown
STREET ADDRESS (If rural give location) 846 Maryland Avenue

3. NAME OF DECEASED: (Type or Print) (First) JOHN (Middle) WILLIAM (Last) WOLF

4. DATE OF DEATH (Month) August (Day) 7 (Year) 1955

5. SEX Male | 6. COLOR OR RACE: White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Widowed | 8. DATE OF BIRTH. June 4, 1870 | 9. AGE last birthday IF UNDER 1 YEAR, IF UNDER 24 HRS. 85 yrs Months 2 Days Hours 3 Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life. even if retired) Retired Moulder | 10B. KIND OF BUSINESS OR INDUSTRY: Statton Furniture Co. | 11. BIRTHPLACE (State or foreign country) Funkstown, Maryland | 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Albert S. Wolf

14. MOTHER'S MAIDEN NAME: Mary C. Shilling

15. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unk.) (If Yes, give war or dates of service) no

16. SOCIAL SECURITY NO. 220-09-7874-A

17. INFORMANT & ADDRESS Mrs. Margaret Yetter Clearspring, Maryland

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X IMMEDIATE CAUSE (A) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 72 hours

ANTECEDENT CAUSE (B) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C) DUE TO

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Cardio Vascular Renal Disease 4 yrs

19A. DATE OF OPERATION: | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | 21E. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-4-45, 19[illegible], to 8-7-45, 19[illegible], that I last saw the deceased alive on [illegible], 19[illegible], and that death occurred at [illegible] M. from the causes and on the date stated above.

SIGNATURE [illegible] M.D. ADDRESS Hagerstown, Md DATE SIGNED 8-8-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF 8/10/55 | NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery | LOCATION (City, town, or county) (State) Hagerstown, Maryland

DATE REC'D BY LOCAL REGISTRAR Aug. 9. 1955 | REGISTRAR'S SIGNATURE Ethel H. Bowers | 24. FUNERAL DIRECTOR C. M. Suter & Sons | ADDRESS Hagerstown, Maryland

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15—10-

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08162

8141

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:
COUNTY Washington MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 23 Hagerstown
LENGTH OF STAY (in this place) 1 wk.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 81 Washington County Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY Frederick
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Middletown
STREET ADDRESS (If rural give location) 10X-2

3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print) Charlotte Olive Lucinda Young

4. DATE OF DEATH: (Month) (Day) (Year) August 5, 1955

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Married

8. DATE OF BIRTH: Dec. 27, 1889

9. AGE last birthday: 65 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY: own Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: John H. Routzahn

14. MOTHER'S MAIDEN NAME: Ida E. J. Remsburg

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. no

17. INFORMANT & ADDRESS: Stanley F. Young Middletown Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

4341

IMMEDIATE CAUSE (A) DUE TO: Renal infarction, acute — INTERVAL BETWEEN ONSET AND DEATH: 1 wk

ANTECEDENT CAUSE (B) DUE TO: Acute congestive heart failure — 1½ yrs.

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(C) Cluttke phenomenon

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/50, 19[illegible], to Aug 4, 1955, that I last saw the deceased alive on Aug 4, 1955, and that death occurred at 9:35 AM, from the causes and on the date stated above.

SIGNATURE Thomas R. C. Benson M. D. ADDRESS Middletown DATE SIGNED 8/5/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
DATE THEREOF: 8-7-55
NAME OF CEMETERY OR CREMATORY: Reformed Cemetery
LOCATION (City, town, or county) (State): Middletown, Md.

DATE REC'D BY LOCAL REGISTRAR: Aug 8, 1955
REGISTRAR'S SIGNATURE: Chas. H. Boeckers

24. FUNERAL DIRECTOR: Gladhill & Co. ADDRESS: Middletown, Md.

VS. A15—10-52

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08163

8142 CERTIFICATE OF DEATH Reg. Dist. No. 302

1. PLACE OF DEATH:
COUNTY Washington MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown
LENGTH OF STAY (in this place) 6 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS 81 Wash. County Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Wash.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hagerstown 03
STREET ADDRESS (If rural give location) 601 W. Washington St. 1

3. NAME OF DECEASED: (Type or Print) (First) Donna (Middle) Sue (Last) Younker
4. DATE OF DEATH: (Month) Aug (Day) 7 (Year) 1955

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Single
8. DATE OF BIRTH: Aug. 1, 1955
9. AGE last birthday yrs. 6
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None
10B. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Hagerstown Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Ellsworth W. Younker
14. MOTHER'S MAIDEN NAME: Susie M. Crouse

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) ---
(If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. ---
17. INFORMANT & ADDRESS: Ellsworth W. Younker Hag. Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
7625 IMMEDIATE CAUSE	(A) Pulmonary Hyalin Membrane	3 days
ANTECEDENT CAUSE (S): DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	DUE TO (B) Atelectasis	3 days
	DUE TO (C) [illegible]	7 days.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/1, 1955, to 8/7, 1955, that I last saw the deceased alive on 8/7, 1955, and that death occurred at 1:45 PM, from the causes and on the date stated above.
SIGNATURE Richard A. Young M. D. ADDRESS Hagerstown Md. DATE SIGNED 8/8/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF 8-8-55
NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery
LOCATION (City, town, or county) (State) Hagerstown Md.

DATE REC'D BY LOCAL REGISTRAR Aug. 8, 1955
REGISTRAR'S SIGNATURE Chas. H. Bowers
24. FUNERAL DIRECTOR Scott F. Minnich & Son
ADDRESS Hag. Md.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10 20852683341